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## PURPOSE

The purpose of this Association shall be to bring into close contact by association and communication lawyers, barristers and solicitors who are residents of the United States of America or of any of its possessions or of any country in the Western Hemisphere, who are actively engaged wholly or partly in the practice of that branch of the law pertaining to the business of insurance in any of its phases or to Insurance Companies; to promote efficiency in that particular branch of the legal profession, and to better protect and promote the interests of insurance Companies authorized to do business in the United States of America or in any country in the Western Hemisphere; and to encourage cordial intercourse among such lawyers, barristers and solicitors, and between them and Insurance Companies generally.

# President's Page

It is incumbent upon each of the members of our Association to be ever aware of trends, movements or practices inimical to the profession generally and to the defense segment of the bar and to resist them with vigor and all proper methods at his disposal. We should strenuously oppose those things which tend to destroy the adversary system of the administration of justice. We should object to procedures sought to be employed in the courtroom which have as their purpose the usurpation of the function of the jury, such as the reference by counsel to the amount of the *ad damnum* clause or the use of blackboards to reflect matters having no foundation in the evidence. On the positive side, we should prepare our cases well, eliminate all dilatory practices, avoid unnecessary delays and otherwise cooperate in the fair and speedy trial and disposition of causes. These are not only fundamental duties of the members of our great profession, but are essential if we are to maintain the prestige of lawyers and prevent erosion of the practice of the law.

The Journal continues to enjoy an outstanding position in the field of legal publications. It is widely read by the insurance industry, lawyers, members of the judiciary and students. Compliments regarding the October, 1959 issue have been numerous. A judge on the Federal Appellate Bench was eloquent in his praise of the Journal generally and that issue in particular. He commented that he read the Journal "from cover to cover". "The greatest Journal yet", was the remark heard from several sources. The Editor and the others who make possible this worthwhile contribution to legal literature are to be congratulated for their efforts. It must be pointed out that to maintain the Journal at its present high level requires the cooperation of each and every member of our Association by being ever alert to articles, interesting cases and other material so necessary to keep the Journal a vital and pulsating legal periodical.

As we reach the halfway mark for the Association year, definite progress can be reported in the various fields in which we and the industry with which we are identified are interested. A majority of our committees are active either with special projects or in supporting the Journal by contributing pertinent articles. Interesting committee reports with constructive recommendations are anticipated at the Midwinter Meeting of the Executive Committee at Camelback Inn, Phoenix, Arizona, in January 1960. Our chairmen and committee members are to be commended for their thoughtful and zealous approach to the work of their committees.

Calendarwise we are embarking on a new year. The members of the Association, their families and our friends are extended best wishes for a happy and prosperous 1960.

CHARLES E. PLEDGER, JR., *President*

# CURRENT DECISIONS

*Recent decisions of the courts dealing with insurance and negligence law and practice are included in these pages. Journal readers are asked to send in digests of such rulings. Unreported cases dealing with novel questions are especially desired. Members of I.A.I.C. should submit their contributions to their State Editors.*

Edited by
R. HARVEY CHAPPELL, JR.
*Richmond, Virginia*

## ATTORNEYS—REGULATION OF CONTINGENT FEES

*Gair v. Peck,* 188 N.Y.S. 2d 491, 160 N.E. 2d 43 (1959)

The Appellate Division of the Supreme Court of New York in the First Judicial Department adopted a rule dealing with contingent fees in claims and actions for personal injury and wrongful death. A declaratory judgment proceeding was brought to test the validity of the rule and the Supreme Court at Special Term held that the justices individually and the court were without power to promulgate and enforce such a rule. The Appellate Division of the Supreme Court in the Third Judicial Department affirmed that judgment. On appeal to the New York Court of Appeals the lower court judgment was reversed, the Court of Appeals holding that the rule (which, in effect, provided for disciplining of attorneys for receiving more from their clients than could legally be collected under retainer agreements) was within the Appellate Division's power to adopt and to enforce. See discussion of this case in XXVI Insurance Counsel Journal 598 (October, 1959).

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## AUTOMOBILE INSURANCE—COOPERATION CLAUSE

*Lumbermens Mutual Casualty Company v. Chapman,* 269 F.2d 478 (4 Cir., 1959)

Lola Chapman was injured while riding in the automobile owned and operated by her brother-in-law, Foster. She sued Foster in a state court of West Virginia and obtained judgment for $7,500.00. The insurer refused to pay on the ground that the insured had failed to cooperate and the present action was brought in federal court by Chapman against the insurer for satisfaction of such judgment. The insurer's defense of failure to cooperate was based primarily on the fact that even though Foster was given an opportunity to employ his own counsel (inasmuch as the Chapman claim was for more than policy coverage) and Foster had been advised not to give information concerning the accident to anyone other than representatives of the insurer, nevertheless, Foster went to the office of Chapman's lawyer on the evening before the trial and Chapman's lawyer conceded that the purpose of this visit was for the lawyer to be able to obtain information to prepare the case for trial. At that evening conference Chapman assured Foster that in the event of a verdict in excess of insurance coverage she would release him from any such excess. The insurer's attorneys knew nothing of this meeting and did not learn of it until the day of the trial at which time they advised Foster that the insurer would continue to defend him but reserving the right to deny liability. Also, there was some variance between Foster's first version of the accident and that version which he testified to at the trial of the Chapman claim and Foster further stated in his testimony that he was legally responsible for the accident. The Fourth Circuit Court of Appeals held that the jury's findings in the suit against the insurer were binding, the jury having found no duplicity on the part of the insured and, therefore, the verdict ought not to be disturbed. However, the court did comment:

> "It is an unseemly insensitiveness to the ethics of his calling for an attorney to interview an opposing party upon the case without the presence or per-

mission of his counsel, if he knows him to be so represented. This is true although the party will be a witness and although a witness, generally, may be questioned without the leave of the other side.***

"For the attorney, no justification can be found in a distinction between Foster insured and Foster uninsured. True, Lumbermens' letter had implied such a difference, but actually there was but a single liability and that the defendant's. The insurer did not have one liability, the defendant another. The company had convenanted to defend the insured's entire and whole liability. A separation existed only in the extent of their responsibility under a judgment.

"The transgression was, however, the attorney's and not the insured's. The unbecoming conduct of the attorney ought not to be laid to his opposite party. The latter is hardly chargeable with the knowledge that the conference was uncanonical. Nevertheless, ordinary candor demanded that he inform his insurer or its counsel of the conference. In this respect the insured did fail in his obligation to his insurer.

"But we cannot conclude that in the circumstances his omission was so substantial as to relieve the insurer from its policy.***"

(Contributed by Paul S. Hudgins, Huntington, West Virginia, State Editor for West Virginia)

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## AUTOMOBILE INSURANCE— INSURER'S CANCELLATION PRIVILEGE

*Jensen v. Traders and General Insurance Company,* 345 P.2d 1 (Cal., 1959)

One DiMatteo signed a conditional sales contract for the purchase of an automobile for his minor son, among the provisions of which contract existed a request that the seller obtain insurance in a company acceptable to it and to include the premiums therefor in the balance due on the conditional sales contract. The insurer upon request of the seller issued its policy, a liability and property damage policy, covering DiMatteo and his son. The DiMatteos received the policy by mail and the premiums were paid from May through November, 1951. The policy contained the standard provision whereby it might be cancelled by the insurer by mailing to the named insured at the address shown on the policy written notice stating when not less than five days thereafter such cancellation should become effective. In August, 1951, two separate notices of cancellation of the policy were deposited in the United States mail, one addressed to DiMatteo and the other to his son. Neither of the letters was returned to the insurer but both DiMatteo and his son denied having received them. The cancellation provision in the policy was attacked in the instant suit on the theory that the language was ambiguous and, further, that such cancellation provision was contrary to the public policy of the State of California. In affirming the lower court's judgment for the defendant insurer, the California Supreme Court stated that the cancellation provision in the automobile insurance policy as above indicated is clear and unambiguous and means exactly what it says. The court further stated that mailing of the notice is the determining factor in cancellation and not the receipt by or delivery to the policyholder. Also, the court held that the parties to an insurance policy are free, subject to legislative restriction, to arrange the occasions and methods and means of cancellation by private agreement, and that such private agreement does not offend the public policy of the State of California.
(Contributed by Gordon H. Snow, Los Angeles, California, Chairman of Journal Committee)

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## AUTOMOBILE INSURANCE— SUDDEN EMERGENCY

*Heerman v. Burke,* 226 F.2d 935 (8 Cir., 1959)

Automobile guest brought suit against her host for injuries sustained in automobile accident. The accident occurred on a smooth and level road, the weather having been hot and dry and the windows of the automobile open. The defendant was wearing a short sleeve sport shirt and was driving with his left elbow resting on the ledge of the left window, both hands on the steering wheel and at a moderate rate of speed. A wasp flew into the defendant's left shirt sleeve and when he grabbed at his shirt with his right hand the wasp stung him in the left armpit. The sting

caused him to jump involuntarily and he applied his brakes hard to bring the car to a sudden stop. The plaintiff was thrown suddenly forward and injured. From a jury verdict in the amount of $10,000.00 for the plaintiff the defendant appealed. The Eighth Circuit Court of Appeals reversed and remanded the cause for a new trial. The court stated that the defendant was entitled to have his case submitted to the jury on the theory of a sudden emergency and that the trial court erred in refusing to do so. (Contributed by J. Kirby Smith, Dallas, Texas, State Editor for Texas)

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**DAMAGES–**
**INCOME TAXES DEDUCTED**

*O'Connor v. United States, 269 F.2d 578* (2 Cir., 1959)

In an action under the Federal Tort Claims Act brought by the administratrix of an engineer against the United States for the engineer's wrongful death, the Second Circuit Court of Appeals affirmed the district court on the issue of liability but reversed and remanded for further hearing and findings on the issue of damages in 251 F.2d 939 (2 Cir., 1958). At the second trial somewhat more extensive proof of damages was offered and the lower court again entered judgment in favor of the administratrix in the amount of $150,000.00 and from this judgment the United States appealed. Of particular interest is the language of the court beginning on page 584 of the opinion, dealing with the consideration to be given income taxes in making an award:

"We are also asked to decide whether income taxes should be taken from the deceased's total salary before computing what part of his earnings would reasonably be expected to go to the benefit of his wife and child. We think that such a deduction should be made. It has been said that future taxes are too uncertain to admit of advanced computation. But it is wholly unrealistic to suppose that, at any time within the limits of the years the deceased could reasonably have been expected to live, either the discontinuance or substantial reduction of Federal Income Taxes would occur. The deceased, as a salaried employee, never had in his own hands the amount withheld from his earnings for Federal Income Tax purposes; and his wife and child could have no direct benefit from that part of his earnings. While mathematical certainty is not possible, any more than it is in a prognosis of life expectancy and future earnings, nevertheless, an estimate may be made based generally on current rates, from which there should be computed the future income of the deceased after payment of Federal Income Taxes rather than before. The compensatory nature of the right to damages under the Tort Claims Act requires such consideration of Federal Income Taxes; the plaintiff-appellee can recover only for losses sustained. There is also an implication that 'take home' pay is considered the proper basis of earnings on the issue of damages in Oklahoma. *Magnolia Petroleum Co. v. Sutton*, 1953, 208 Okla. 488, 257 P.2d 307; Note, 'Wrongful Death and Survival Actions,' 6 Okla. L. Rev. 384, 386 (1953)."

(Contributed by John A. Kluwin, Milwaukee, Wisconsin)

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**DAMAGES–**
**LOSS OF USE OF**
**PERSONAL PROPERTY**

*Reynolds v. Bank of America, N.T.S.A., Executor* (S.F. No. 20, 165; Supreme Court of California; Filed November 13, 1959)

Insured, in an action against insurer, sought not only general damages for the loss of an airplane which was abandoned at sea but, also, damages for loss of use of such airplane for the time estimated by the insured to be necessary to replace the particular type of aircraft as well as loss of business profits. The trial court refused the portion of the insured's claim dealing with loss of use and loss of business profits relying on an established line of California cases which have held that there can be no recovery for destroyed personal property upon the basic theory that the property can be replaced and, therefore, damages for loss of use and profits are not consistent therewith. However, on appeal the California Supreme Court overruled the trial court, indicating that there appeared to be no logical reason why there should be a distinction drawn between cases in which the property is totally destroyed and those in which it has been injured but

is repairable. The case was remanded for retrial on this sole issue to allow the plaintiff to prove his special damages in addition to the value of the lost airplane. (Contributed by Gordon H. Snow, Los Angeles, California, Chairman of Journal Committee)

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**DISCOVERY—**
**DISCLOSURE OF WITNESSES' NAMES NOT REQUIRED**

*Ex parte Ladon,* 325 S.W. 2d 121 (Tex. 1959)

In a suit by a passenger against a transit company for injuries sustained when a bus stopped suddenly, the passenger filed a "Motion for Discovery" alleging that Ladon, the general trial attorney for the transit company, had in his possession certain names of witnesses to the accident upon which the suit was based and the passenger prayed that the court order the attorney to produce such names and permit her to inspect and copy them. Upon the hearing of this motion the attorney stipulated that he did in fact have in his possession such names and the lower court thereupon directed that he deliver the record of the names of all such witnesses but he refused to do so. A hearing then was held and the attorney was found guilty of contempt. A writ of habeas corpus was issued by the Supreme Court of Texas for the release of the attorney from the custody of the sheriff. The Supreme Court held that the attorney should be discharged inasmuch as Rule 167 of the Texas Rules did not require the attorney to disclose the witnesses' names.

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**EXCESS LIABILITY—**
**GOOD FAITH OF INSURER**

*Moore v. Columbia Casualty Company,* 174 F. Supp. 566 (S.D., Ill., 1959)

Insured sued insurer to recover the amount of judgment in excess of policy limits paid by the insured. When the insured originally was sued he forwarded the suit papers to the insurer stating that the suit was fraudulent and that the allegations of the then plaintiff were false, there having been no such accident. The insurer entered defense on behalf of the insured and also advised him that the suit was in excess of policy limits whereupon he did employ individual counsel. The insured's deposition prior to trial again reaffirmed his position that the suit was groundless and fraudulent but, subsequently, the insured wrote to his insurer stating he believed the suit could be settled and demanded that settlement be made. The insurer answered, requesting of the insured any facts or grounds that he had not revealed which would justify settlement and the insured again replied that the suit was based on false and fraudulent grounds. Upon trial the jury returned a verdict for $35,000.00 and the liability limit was only $10,000.00. Subsequently, the judgment was settled for $20,000.00, the insurer having paid its limit and the insured having paid the additional $10,000.00. The present action was predicated on both negligence and breach of good faith to recover the $10,000.00 paid by the insured plus costs, expenses and attorney's fees. The Illinois United States District Court entered a summary judgment in favor of the defendant insurer holding that in the light of the insured's continued assertions that the suit against him was false and fraudulent, based on untrue allegations and perjury, it scarcely could be said that his carrier was negligent or acted in bad faith in failing or refusing to settle the suit, if such could have been done, within policy limits. (Contributed by J. Kirby Smith, Dallas, Texas, State Editor for Texas)

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**EXCESS LIABILITY—**
**ISSUE OF NEGLIGENCE MUST BE CONSIDERED FROM INSURER'S POINT OF VIEW ALSO**

*Fidelity and Casualty Company of New York v. Robb,* 267 F.2d 473 (5 Cir., 1959)

The insured brought suit against insurer to recover the amount of a judgment in excess of policy limits on the grounds (1) that the insurer was negligent in failing to settle within the policy limits and (2) that the insurer was negligent after the original settlement offer was withdrawn in failing to initiate and carry out settlement negotiations in an effort to effect the settlement within such policy limits. The jury returned a verdict in favor of the insurer on the first issue and in favor of the insured on the second issue, the judgment in the latter case having been for

$47,290.00. On appeal, the Fifth Circuit Court of Appeals, applying Texas law, held that the so-called negligence rule prevailed and controlled their decision but that the charge of the lower court was erroneous inasmuch as the case was sent to the jury in such a manner as to give consideration only to the interest of the insured and the interest of the insurer was completely rejected. The jury should have been instructed that in determining whether insurer was negligent the matter should be looked at from the standpoint of both insured and insurer. Therefore, because of defect in the charge, the judgment was reversed and the cause remanded. (Contributed by J. Kirby Smith, Dallas, Texas, State Editor for Texas)

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**FIRE INSURANCE–**
**INTERIM OCCUPATION DOES NOT NULLIFY VACANCY WAIVER**

*McKinney v. Providence Washington Insurance Co.*, 109 S.E.2d 480 (W. Va., 1959)

In an action on an insurance policy the insured introduced evidence to the effect that a duly authorized agent of the insurer knew at the time the subject fire policy was issued that the building was vacant, the policy having been issued on October 10, 1953, and the fire having occurred November 2, 1955, on both of which occasions the building was vacant. However, within eight or ten days after the policy was written a tenant actually occupied the dwelling and continued to do so until sometime during the month of July, 1955. The Supreme Court of Appeals of West Virginia held that the vacancy provision which would have voided the policy was waived and the interim occupation of the premises did not serve to nullify such waiver, the court having observed that the building "*** was just as vacant when the policy was issued as it was when it was destroyed by fire." (Contributed by Paul S. Hudgins, Huntington, West Virginia, State Editor for West Virginia)

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**LIABILITY–**
**GOVERNMENTAL IMMUNITY DOES NOT EXTEND TO NEGLIGENT POLICE OFFICER**

*Moore v. Cook*, 22 Ill. App. 2d 48, 159 N.E.2d 496 (1959)

A motorist brought suit against a police officer for personal injuries and property damage sustained when the automobile of the motorist was struck by an automobile operated by a police officer while pursuing a traffic violator. The lower court entered judgment in favor of the motorist and, on appeal, the Appellate Court of Illinois held that a municipal officer may be held liable for negligence in the course of his duty, even though the municipality is exempted from such liability because a governmental function is involved. The Appellate Court declined to follow the rule set out in *Taylor v. City of Berwyn*, 372 Ill. 124, 22 N.E.2d 930 (1939) in which opinion it was stated that since the officer was "actively engaged in the performance of a governmental function on behalf of the City of Berwyn at the time of the collision, the judgment of the trial court as to him was erroneous." The court observed that the decision does not conform to current legislative policy as evidenced by statutes since enacted nor is it in accord with the general rule in several states to the effect that the policeman is individually liable for his tort, notwithstanding the fact that he commits it while engaged in performance of a governmental function. Compare *Peters v. Bellinger*, 159 N.E.2d 528 (Ill., 1959) in which city was held liable for tortious act of police officer. (Contributed by Joseph W. Griffin, Chicago, Illinois, State Editor for Illinois)

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**LIFE INSURANCE–**
**INTERPRETATION OF "EXTERNAL MEANS"**

*McCallum v. Mutual Life Insurance Co. of New York*, 175 F. Supp. 3 (E.D. Va., 1959)

Beneficiary brought suit against insurer for death benefits allegedly due under the double indemnity provisions of life insurance policies. Upon motion by both parties for summary judgment the United States District Court for the Eastern District of Virginia sustained the motion of the defendant insurer. The case, as presented by the insurer's motion, turned on the interpretation of the words "external means". The court held that where the insured died as the result of aspiration of gastric contents into the trachea, assuming arguendo that the insured's death was violent and

accidental, nevertheless, insured did not die from injuries solely through "external means" within the double indemnity provisions of the subject policies by reason of fact that the substance which caused death was no longer food but was in the insured's body and was being expelled therefrom in the process of vomiting. (Contributed by A. C. Epps, Richmond, Virginia.)

## MALPRACTICE ACTION— DEGREE OF PROOF REQUIRED REAFFIRMED

*Carroll v. Richardson,* 110 S.E.2d 193 (Va., 1959)

Plaintiff sued for personal injuries sustained when he fainted and fell to the floor after a blood sample had been removed from his arm by an employee of the defendant, a doctor. The lower court entered judgment on a verdict for the plaintiff and on appeal the Supreme Court of Appeals of Virginia reversed the lower court and entered final judgment for the defendant. The court reaffirmed its position taken in *Alexander v. Hill,* 174 Va. 248, 6 S.E.2d 661 (1940), wherein it was held that a physician is not required to exercise the highest degree of skill and diligence possible in the treatment of an injury unless he has by special contract agreed to do so. In the absence of such special contract he is only required to exercise such reasonable and ordinary skill and diligence as are ordinarily exercised by the average of the members of the profession in good standing, in similar localities and in the same general line of practice, regard being had to the state of medical science at the time. In the instant case the court held that the evidence as tested in the light of these principals failed to make out a case against the defendant inasmuch as there was no proof that the defendant was guilty of any negligence in the manner complained of nor was there evidence that he or his servant failed to follow the usual and approved custom and practice in this instance.

## OMNIBUS CLAUSE— INAPPLICABLE TO MILITARY VEHICLES

*All state Insurance Company v. Hoffman,* 21 I.A.2d 314, 158 N.E.2d 428 (1959)

Insurer brought declaratory judgment action to determine liability under automobile insurance policy. The insured was involved in an accident between a truck which he was driving as a member of the Illinois National Guard and a motor vehicle in which Edward and Frances Grochowski allegedly were injured. The truck was owned by the Illinois National Guard and was in convoy from Camp Ripley, Minnesota, to the home armory in Chicago, Illinois. The insurer contended that there was no coverage by reason of the provisions of the policy whereby it was provided that the policy did not cover any non-owned automobile "while used in the business or occupation of the named insured." The insurer further contended that even if coverage was afforded the insured had forfeited his right thereto by failing to give written notice of the accident as soon as practicable under the terms of the policy. The Appellate Court of Illinois concluded that Hoffman's liability, if any, to the Grochowskis was excluded from the coverage provided by the policy and that the insurer owed no duty under the policy in question. The court also held that timely notice had not been given by the insured. See, also, *Voelker v. Travelers Indemnity Company,* 260 F. 2d 275 (7 Cir., 1958) XXVI Insur-Counsel Journal 170 (April, 1959). (Contributed by Joseph W. Griffin, Chicago, Illinois, State Editor for Illinois)

## PRODUCTS LIABILITY— PRYOR CASE REVISITED

*Pryor v. Lee C. Moore Corporation,* 262 F.2d 673 (10 Cir., 1959)

This case was reported in XXVI Insurance Counsel Journal 455 (October, 1959) to the effect that a jury question was presented in determining whether or not a defective weld at the foot of one leg of a derrick caused the derrick to collapse under ordinary pressure being applied in the routine operation after fifteen years of safe use. The Tenth Circuit Court of Appeals was persuaded "to recede from the rule" in *Lynch v. International Harvester Company,* 60 F.2d 223 (10 Cir., 1932) in which it was held that five years of constant use of a threshing machine was a conclusive denial and contradiction of allegations that the machine was imminently dangerous when the defendant sold it. The defendant then filed a petition for writ of

certiorari with the United States Supreme Court but the petition was denied. The case was retried before the United States District Court for the Western District of Oklahoma in September, 1959, and plaintiff and defendant again presented their evidence as to the allegedly defective weld as well as the alleged disability of the plaintiff. At the conclusion of the evidence the court instructed the jury pursuant to the law set forth in the above mentioned opinion of the Tenth Circuit Court of Appeals and the jury, after deliberating approximately twelve minutes, returned a verdict in favor of the defendant. (Contributed by Alex Cheek, Oklahoma City, Oklahoma)

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## TRIAL TACTICS— EMOTIONAL APPEAL TO JURY

*Klotz v. Sears, Roebuck & Company,* 267 F.2d 53 (7 Cir., 1959)

Buyer brought suit against seller for personal injuries sustained as a result of the explosion of a sprayer purchased from seller. The lower court entered judgment on a $100,000.00 verdict for the buyer and the seller appealed. The Seventh Circuit Court of Appeals reversed the judgment and remanded the cause for a new trial because of improper remarks made by plaintiff's counsel in argument to the jury. In summarizing such improper conduct on the part of plaintiff's counsel the court stated:

> "During the course of argument to the jury plaintiff's counsel, after having twice entreated the jurors to 'do unto others as you would have them do unto you' asked the jury to test the sincerity of the argument to be made on behalf of the defendant by what defendant's counsel would 'have taken for his eye'. The Court on the defendant's objection instructed the jury to disregard the remark.
>
> "Earlier plaintiff's counsel had stated 'I don't think, ladies and gentlemen, no matter how much money this man is awarded - and I am telling Mr. Parsons to tell us what he will take for his eye, when he was 28 - no matter what you give him it won't be enough'.
>
> "At another point, over defendant's objection, reference was made to a hypothetical discussion between plaintiff and a friend of the same age, also attending school, in which, on the assumption that an eye could be successfully transferred from one person to another, plaintiff seeks to purchase his friend's eye. Plaintiff's counsel was permitted to pose the rhetorical question 'What is the eye worth and what could you get anybody to give it to you for?' Before reference was made to this hypothetical discussion plaintiff's counsel had stated 'Back in 1956 Sears, Roebuck and Company bought Mr. Klotz' eye. It is your job today to decide what he is going to sell it for.' This followed a reference to the effect that the defendant fixes the price of things it sells 'and you pay it or else'. Defendant objected and the Court advised the jury that they could disregard the remark.
>
> "Plaintiff's counsel closed his argument with the plea 'We ask you to give us the kind of a deal that you would want to get'."

The court then observed:

> "These remarks made by plaintiff's counsel were in effect pleas that the jury permit sympathy, rather than the facts in evidence to determine the issues.***
>
> "The fact that the defendant did not object to some of the remarks and on objections the Court instructed the jury to disregard others does not, in our view, on the record before us, sustain the District Court's denial of a new trial.
>
> "Prejudicial argument of counsel of the character here indulged in is sufficient cause for reversing a judgment even though the trial court has sustained objections to the statements and directed the jury to disregard them***."

(Contributed by James P. Allen, Jr., Boston, Massachusetts, Northeastern Regional Editor)

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## WINDSTORM INSURANCE— FOOD LOSS COVERED IN POWER FAILURE

*Lipshultz v. General Insurance Company of America,* 96 N.W.2d 880 (Minn., 1959)

Insureds sought to recover under a windstorm policy for damage to perishable foodstuffs in their store following an interruption of electrical service due to a wind-caused break in power lines supply-

ing the area in which the insureds' store was located. The insurer contended that there was no "direct loss" under the terms of the policy. The Supreme Court of Minnesota held that the probability of interruption by windstorm was not beyond the common knowledge of the insurer and insureds and, therefore, the loss of the insureds' foodstuffs as a result of the power failure constituted a "direct loss by windstorm" within the terms of the policy. Judgments for the insureds were affirmed. See, however, *Abady v. Hanover Fire Insurance Company,* 266 F.2d 362 (4 Cir., 1959), XXVI Insurance Counsel Journal 453 (October, 1959).

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**WORKMEN'S COMPENSATION—BORROWED EMPLOYEE**

*Hughes v. Deckard,* 267 F.2d 697 (5 Cir., 1959)

Deckard Drilling Company drilling an oil well needed butane gas in its drilling operations and ordered a tank of butane gas from Planters Butane. The area in the vicinity of the well was muddy and slick and Planters Butane was advised that the truck could not get through unless it was equipped with chains. Since the Planters Butane truck did not have chains it was arranged that a Deckard truck would meet the Planters Butane truck and pull it over the levy and tow it to the well. Hughes, the Planters Butane truck driver, was injured while Deckard's truck was pulling the Planters Butane truck over the levy. Hughes brough suit against Deckard to recover damages for his injuries and Deckard defended on the ground that at the time of the accident Hughes was acting in the capacity of a borrowed employee and hence his exclusive remedy was within the Louisiana Workmen's Compensation Act. The trial judge held that Hughes was a borrowed employee and entered summary judgment for defendant. On appeal, the Fifth Circuit Court of Appeals reversed and remanded the cause holding that it was not established as a matter of law that Deckard was the vicarious master of Hughes. As long as the employee is furthering the business of his general employer by the service rendered to another, there will be no inference of a new relation unless command has been surrendered and no inference of its surrender from the mere fact of its division. A jury question existed. See *Anderson v. Thorington Construction Company,* 110 S.E. 2d 396 (Va., 1959).

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**WORKMEN'S COMPENSATION—LUNCH TIME INJURY COMPENSABLE**

*Thompson v. Otis Elevator Company,* 324 S.W.2d 755 (Mo., 1959)

While on her lunch hour, a female employee went to the women's lounge located on the floor where she worked and was about to apply her cosmetics when she fell over backwards in the floor and was injured. Among other points, the employer and insurer contended that the injury did not arise in the course of her employment. They argued that the employee did not have to go to the lounge at the time she was injured because she was not then doing anything connected with her work, that the applying of cosmetics was not incidental to her employment and that she was still on her lunch hour. The St. Louis Court of Appeals held that the workmen's compensation law should receive a liberal construction as to the rights of employees and that the claimant was injured while performing an act incidental to an arising in the course of her employment. No rule of the employer was violated and she was in a place provided by the employer doing what should have been expected, namely, applying cosmetics.

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# *From the* EDITOR'S NOTEBOOK

***In this column, from time to time, the Editor will publish news and views that he believes may be of more than passing interest to the readers of the Journal. Any opinions expressed are either the personal sentiments of the Editor or are the opinions of those persons to whom they are attributed. Contributions to this column will be welcomed.***

JUST two short years ago, on February 3, 1958, *Botta v. Brunner*[1] became a leading case. As you know, that case condemned the practice of suggesting to the jury, by some imaginary mathematical formula, the amount it should award for each minute or hour or day for pain and suffering; and held it improper to display to the jury charts or blackboards showing calculations of the amounts that counsel contended should be awarded to his client. *Botta v. Brunner* also aligned New Jersey with the other states prohibiting disclosure to the jury of the amount of the *ad damnum* claimed in the suit.

The ink was scarcely dry on the printed reports of this land-mark decision when the plaintiffs' bar began to show its consternation. One writer said[2]:

> "The philosophy of the opinion is as bigoted as the objection of the medieval clergy to translating the Bible into English because it invaded their province. *** The opinion is the most dangerous abridgement of the prerogative of counsel since Erskine defied the King of England."

The NACCA News Letter said that "the body of tort law" had suffered "a setback" by this "restrictive decision". At a national meeting, the NACCA lawyers present were told:

> "This is a case that will harm you unless we can figure out a way to get around it."

And so the battle lines were drawn!

In November, 1958, the Supreme Court of Delaware spoke on these subjects in *Henne v. Balick*, 146 A.2d 394. That court went directly to the heart of the matter in its statement:

> "We are also clearly of the opinion that in many cases at least the purpose of such use is *solely* to introduce and keep before the jury figures out of all proportion to those which the jury would otherwise have had in mind, *with the view of securing from the jury a verdict much larger that that warranted by the evidence.*"
>
> (Emphasis added).

A Michigan Supreme Court decision[3] has followed the same principle in refusing to permit *voir dire* of jurors as to whether they felt the amount of the *ad damnum* was "just too much money, no matter what the proofs show so far as damages are concerned".

The North Dakota Supreme Court has said[4]:

> "The determination of damages for pain and suffering is not susceptible of arithmetical calculation."

Pennsylvania is clearly in line with the rule of *Botta v. Brunner*,[5] and its decisions over the years have served as the foundation for the wholesome trend of judicial pronouncements in this important field. In Tennessee the courts say that "there is no fixed rule by which damages for personal injuries can be ascertained or mathematically calculated."[6]

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[1]26 N.J. 82, 138 A. 2d 713, 60 A.L.R. 2d 1331. See also annotation in 60 A.L.R. 2d 1347, and Report of Practice and Procedure Committee-1959, 26 Insurance Counsel Journal 497.

[2]See 25 Insurance Counsel Journal 388, quoting The Journal of the Alabama Plaintiffs' Lawyers Association.

[3]*Spelker v. Knobloch*, 354 Mich. 276, 93 N.W. 2d 276.

[4]*Lake v. Neubauer*, 87 N.W. 2d 888.

[5]See *Joyce v. Smith*, 269 Pa. 439, 112 A. 2d 549; *Quinn v. Philadelphia Rapid Transit Company*, 224 Pa. 162, 73 A. 319; *Stein v. Meyer*, 150 F. Supp. 365.

[6]See *Yellow Cab v. Jelps*, 9 Tenn. App. 288.

And in Virginia, in June, 1959, the Supreme Court of Appeals of Virginia held[7] that the use by plaintiff's counsel of a mathematical formula setting forth on a blackboard the claims of pain, suffering, mental anguish, and the percentage of disability suggested by him on a per diem or other fixed basis, was "speculation of counsel unsupported by evidence, amounting to his giving testimony in his summation argument," and that it was improper and constituted error.

Another recent decision following *Botta v. Brunner* is that of the Supreme Court of Missouri, Division Number Two, in *Faught v. Washam*,[8] wherein Rose, J., says:

> "To us, the considerations advanced by the authorities disapproving the mathematical formula argument are more persuasive. Whatever may be the cold logic or academic theory of the matter, the ungilded reality is that such argument is calculated and designed to implant in the jurors' minds definite figures and amounts not theretofore in the record (and which otherwise could not get into the record) and to influence the jurors to adopt those figures and amounts in evaluating pain and suffering and in admeasuring damages therefor"

In Ohio, the latest decision of the Supreme Court[9] says:

"Of all the items of compensatory damages which it may become the duty of a court or jury to assess, that which will compensate for human pain and suffering is perhaps the most difficult to determine. *Such determination is susceptible of no mathematical or rule of thumb computation,* and no substitute for simple human evaluation has been authoritatively suggested." (Emphasis added).

Throughout the land other cases raising the points decided in *Botta v. Brunner* are pending before the courts. In state after state defense lawyers are effectively using these precedents and principles to combat improper tactics of plaintiffs' counsel seeking verdicts in astronomical figures. The courts are showing their awareness of the public concern over unconscionable verdicts in amounts far greater than justified by evidence, and are recognizing that the methods of the plaintiffs' bar have substantially contributed to the rendition of such verdicts.

The trend is apparent!

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"Reviewing the Law Reviews" is a new feature making its first appearance in this issue of the Journal, beginning on page 18. It is intended to bring to the attention of our readers law review articles of particular significance to practitioners in the fields of insurance and negligence law.

We are fortunate to have, as the conductor of this department, Mr. Robert J. Nordstrom, associate dean and professor of law at Ohio State University's College of Law. Dean Nordstrom holds a Juris Doctor degree from the University of Michigan Law School, formerly practiced his profession in Providence, Rhode Island, is active in bar association work, and is chairman of the Mershon National Security Program at Ohio State. He tells us that he read exactly 200 law review articles while preparing the material contained in "Reviewing the Law Reviews" for the Journal.

Dean Nordstrom and your editor will appreciate your suggestions as to how this department can be made of the greatest help to you in your work.

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We always hesitate to call attention to particular articles in the Journal, because virtually all of the papers that we publish are outstanding. However, we cannot resist the temptation to suggest that you be sure to read, "The Insurer's Choice: Prepare or Lose", by J. Harry LaBrum (page 35), and "The Impact on the Casualty Insurance Industry of Recent Developments in the Personal Injury Litigation Field", by R. Newell Lusby (page 23). In these days of ever-increasing activity by organized groups of plaintiffs' lawyers, when inflated verdicts are of nationwide concern, and when there is talk of compensation plans for victims of automobile accidents, these articles are of major importance.

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"Loyalty" has been defined as "faithfulness to a cause or a person". Such loyalty between the insurance companies and their defense counsel has done much to make the insurance industry great.

[7] *Certified T.V. & Appliance Co. v. Harrington*, 109 S.E. 2d 126.

[8] Case No. 47,064, as yet unreported.

[9] Flory v. New York Central Rd. Co., 170 Ohio St. 185,190,—N.E. 2d ——, decided December 23, 1959.

In the important traffic accident field, the insurance industry and the defense bar are rendering an indispensable service. This service benefits not only motor vehicle owners (of whom the family-purpose-automobile group is the largest and most important) but also every person in the land, any one of whom may be a traffic accident victim any day. Because the greatness of the insurance industry and its established financial welfare contribute so much to the security of each and every American, the reciprocal loyalties of the insurance industry and the defense counsel have an important share in maintaining our American way of life.

On the one hand, the insurance defense lawyers have proved their loyalty to their insurance company clients by laboring steadfastly in their behalf—sometimes against enormous odds—in striving for prompt, efficient, ethical, fair and just disposition of litigation. These defense lawyers take justifiable pride in being a part of the insurance industry, and they stand forth as its champions not only in the courts, but also in their home communities, their service clubs, churches, bar associations, chambers of commerce, civic groups, and before their state legislatures. They devote countless hours to continuing postgraduate education so that they may be fully qualified to render the best possible service to their clients. They expand their libraries, increase their office personnel, and constantly search for more effective and efficient methods of performing their work. And they cast but few envious glances at the infinitely more lucrative fees received by their professional brethren on the plaintiffs' side of the trial table.

On the other hand, the insurance companies, themselves, display a genuine loyalty to their defense lawyers. They recognize that these men are, indeed, the champions of the insurance industry. They know full well that these defense lawyers are leaders and highly respected in their own communities and that their standing reflects favorably upon the clients whom they represent. It is the common experience to observe situations in which the same lawyers have represented the same insurance companies for a quarter or half a century, and from generation to generation. It is to such lawyers that the insurance companies know that they can always turn for counsel and service—without fear that they may be found on the side of the opposition.

In these circumstances, it is only natural that the insurance companies and their defense lawyers go forward into this New Year in a spirit of mutual trust and confidence and dedicated to a common cause.

# OUR READERS SPEAK

*Readers of the Journal are invited to use this department as a place to express their thoughts on subjects of insurance law, trial practice, and the like. The opinions expressed are, of course, those of the writers and are not necessarily the views of the Journal or the Association.*

Editor of the Journal
Dear Sir:

What is the liability of the insurer when a permittee uses a vehicle for purposes not intended by the owner?

This question was referred to in an article printed in the April, 1959, issue of the Insurance Counsel Journal under the title, "Coverage Arising from the Questions of Permissive Use or Agency". At the time this article appeared, we were very much interested in the problem of whether or not a truck driver was entitled to the protection of a liability policy on the truck he had been driving when he became involved in a serious accident after he had partaken of the contents of a bottle of gin, failed to call on several regular customers on his route, and then started across country to find out what his wife might be doing after the quarrel they had had the night before.

The general statement made on page 264 of the Journal article indicated that "the law of agency and of scope of the employment has no application to coverage under the omnibus clause". This provided a challenge to us and did not agree with what we had discovered in some Ohio cases, so that we were moved to add our small contribution to the print and weight of this issue of the Journal.

Fortunately, for those of us who represent insurance companies in Ohio, there is the case of *Gulla v. Reynolds*, 151 Ohio St. 147, 85 N.E. 2d 116, in which the first and third syllabi are as follows:

> "1. Under the provisions of an automobile liability insurance policy in which the coverage is extended to include a third person, if the actual use of the automobile is with the permission of the named insured, such permission relates to the use to which the automobile is being put by such person *at the time of the accident*. (Emphasis added).
>
> "3. Under such provisions, coverage is not afforded when the use made of the motor vehicle constitutes a complete departure from that for which permission was granted."

The *Gulla* case was decided in 1949 and has been followed in several later cases. The facts in that case involved a furniture dealer who employed Reynolds to make some deliveries in a truck owned by the dealer. Reynolds completed the deliveries and then returned to the furniture store where he purchased a baby bed and asked permission to use the truck in order to take the bed to his home. Permission was granted and Reynolds left the store with the bed on the truck. Several hours later and several miles away, Reynolds was involved in an accident.

A judgment for $30,000.00 was obtained against Reynolds, which was not paid and a supplemental petition was filed against The Buckeye Union Casualty Company, as the liability carrier on the truck. It was the contention of Buckeye that there was no coverage because the original permission to take the baby bed home did not extend to the use being made at the time of the accident. This view was upheld by the trial court, court of appeals, and Supreme Court of Ohio.

In view of the fact that there are suits now pending that have arisen from the situation referred to in our first paragraph, we shall not be any more specific than we have been about our conclusions as to strategy in handling the defense of these suits.

We do want to call attention to the annotation in 5 A.L.R. 2d 621, on this question of the scope of permission. There are various rules followed in different states. It is pointed out that there are three groups of cases. One group is based upon the rule that the use at the time of the accident must be within the scope of the original permission in order to provide insurance

coverage. The group at the other extreme is based upon the rule that it makes no difference about the use at the time of the accident, as long as there was original permission. The third group is in between and applies a test based upon the degree of deviation. In other words, this last group looks to see how far removed the use is from that which was originally intended.

According to the annotation, the states which are listed in the first category requiring strict compliance with the original permission are Maine, Michigan and New Hampshire. Those following the rule that the initial permission covers any use are listed as being Connecticut, Illinois, Louisiana, Massachusetts, New Jersey, Tennessee, Wisconsin and probably North Dakota and Oregon. The in-between group which examines the extent of deviation, is made up of Georgia, Kentucky, Ohio, Oklahoma, Pennsylvania, Texas and Washington.

All of this is separate and apart from the question of whether or not a second permittee would be recognized as an additional insured under the omnibus clause of the typical liability policy, which was the main point discussed in the article in April. We merely want to call attention to the fact that different jurisdictions have applied different tests to the determination of the scope of the permission given to the first permittee.

Robert C. Alexander
*Dayton, Ohio*

August 22, 1959

# Reviewing the LAW REVIEWS

ROBERT J. NORDSTROM*
*Columbus, Ohio*

## LIABILITY OF MEDICAL PRACTITIONERS

Here is an article which should be read by every lawyer who advises doctors or who advises patients with claims against doctors for negligent treatment. Its nearly 100 pages have two primary values for the busy lawyer:

(1) *The arrangement of the negligence problems.* The author's outline begins with the duty of doctors (must he treat all who come to his door? must he treat those whom he has promised to assist? if he begins treatment, how long must it continue?) and moves through a discussion of standards of conduct (including the specialist and a consideration of the effect of the locality in which the doctor lives); specific duties (what is the doctor's legal obligation to keep abreast of progress? to inform his patient of his ailment? to refer him to a specialist? does the doctor have a duty not to experiment on a patient?); vicarious liability for conduct of nurses, x-ray technicians and assistants; "customary practice" as a standard of care; and proving the case by expert testimony or res ipsa loquitur when medical "silence" blocks the use of testimony.

(2) *The citation and discussion of decided cases.* The article collects hundreds of cases—it has 411 footnotes—and discusses the facts and holdings of scores of them. This should put that illusive "case in point" at the finger-tips of the busy practitioner.

The value of this article extends beyond the two points listed above. Several suggestions as to the future direction of the law are found in its pages along with a citation of other articles and books bearing on the liability of medical practitioners. It has no general conclusion which cuts across the entire ariticle but its last two pages deal pointedly with the complaint of plaintiffs' attorneys that there has been a "conspiracy of silence" on the part of the medical profession designed to protect its members. The author shows how courts are moving to meet the problem by: liberalizing qualifications of the expert witness, allowing plaintiff to rely on defendant's testimony to establish his case, and extending the doctrine of res ipsa loquitur to the suits. McCoid, The Care Required of Medical Practitioners. 12 Vanderbilt Law Review 549-632.

Vanderbilt School of Law
Nashville 5, Tennessee

$2.00 per issue.

## PROFESSIONAL NEGLIGENCE

A "must" for the negligence lawyer is the June, 1959, issue of the Vanderbilt Law Review. The entire issue is devoted to professional negligence and deals with the tort liability of medical practitioners (see review above), pharmacists, architects, engineers, teachers, attorneys, abstracters, and public accountants. In addition, there are articles on techniques in the preparation and trial of a medical malpractice suit, medical malpractice insurance, and (for attorneys) an appraisal of Canons 28 and 29. The symposium is rounded out with a treatment of developments in the English law of medical liability.

*Associate Dean and Professor of Law, College of Law, Ohio State University.

Two student notes in this issue continue its theme by treating the liability of insurance agents and funeral directors. This latter subject is one which has received little prior treatment in the reviews.

One of its articles is reviewed above (McCoid, The Care Required of Medical Practitioners). One other article worth special mention is Fitz-Gerald Ames, Sr., Modern Techniques in the Preparation and Trail of a Medical Malpractice Suit (pages 649-666). This contains a practical discussion of the voir dire examination, the preparation of the trial, the pleading, and trial techniques. It complements well the other articles in this review.

12 Vanderbilt Law Review 535-969
Vanderbilt School of Law
Nashville 5, Tennessee

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## COMPENSATION FOR AUTOMOBILE ACCIDENTS

Taking up a 30-year old problem which has found its share of proponents and opponents in the last decade, Professor Fleming James, Jr., (Yale University Law School) attempts to meet the basic arguments advanced against a system of automobile accident compensation. These are that a system of compensation: (1) invites carelessness; (2) is too expensive; (3) allows only "pitifully small awards"; (4) promotes malingering and fraud; and (5) threatens jury trials. He concludes that "*(a)11* compensation systems proceed on a basically more equitable principle of distributing payments for accident losses than does the common law".

This will not be the last plea for or against a change in our common law system as it applies to the automobile, but it is a well-thought-through article that should be given careful consideration by the personal injury lawyer as well as the "lawyer-citizen". Whether the reader will feel that the arguments against a system of compensation have been met by Professor James may depend, however, on something other than logic. As James puts the "heart of the problem", the real objection to such a system "divides men philosophically". These are hard legal battles to solve. James, The Columbia Study of Compensation for Automobile Accidents: an Unanswered Challenge. 59 Columbia Law Review 408-425.

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## PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT

Professor Clinton DeWitt (Western Reserve University School of Law) joins Wigmore, Greenleaf and perhaps a score of other writers in condemning the physician-patient privilege rule. There is no doubt as to DeWitt's position. The last sentence of the article states: "It's high time to abolish the physician-patient privilege." No double-talk there. His footnotes collect not only a number of cases but also a series of law review articles which apparently raise serious doubt as to the privilege. This article should be a good research tool for the lawyer seeking to attack or to limit the rule in his jurisdiction. DeWitt, Privileged Communications between Physician and Patient. 10 Western Reserve Law Review 488-501.

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## CONDITIONAL FAULT

One of the most penetrating discussions of the doctrine of fault in the tort area is found in an article by Professor Robert E. Keeton (Harvard Law School). This article is not one that is to be glanced at casually but requires two or three careful readings before its full impact is realized. It is one that will undoubtedly be cited in the years to come and could have a strong influence on appellate decisions.

The author deals with a topic which he has labeled "conditional fault". He introduces this concept with eight hypotheticals, discusses them for four pages, and then attempts to meet criticisms that he antici-

pates will be made to his suggestions. The concept of conditional fault brings together ideas of blameworthiness (to use Professor Keeton's phrase), moral elements, and risk-spreading capacity.

This article will be of value to attorneys who urge that fault should not be supplanted by a doctrine of compensation from the most efficient risk spreader (in many cases, the insurance company). "Thus, modern decisions imposing liability for non-negligent, risky conduct appear not as developments threatening to supplant blameworthiness as the theme of liability in tort, but rather as a trend consistent with that theme and with its application in relation to the somewhat nicer and perhaps more debatable moral discriminations of conditional fault....(C) oncepts of individual responsibility, with moral content, remain vital to an understanding of tort decisions and trends." (Page 444). Keeton, Conditional Fault in the Law of Torts, 72 Harv. Law Rev. 401-44.

Harvard Law School
Cambridge, Massachusetts

$2.15 per issue for back numbers.

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**DAMAGES FOR PERSONAL INJURIES**

This issue of the Ohio State Law Journal is now 18 months old. It is mentioned here solely for those who may have overlooked this particular copy which deals exclusively with personal injury damages. Articles include recovery for pain and suffering, profits, and wrongful death. Also included are treatments of the jury and damages, income taxes, actuarial tables, and the pros and cons of discarding fault in negligence cases. 19 Ohio State Law Journal 155-312.

Ohio State University College of Law.
Columbus, Ohio
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**TORT LIABILITY OF AN INSURER**

The now famous Alabama case of *Liberty Nat't Life Ins. Co. v. Weldon* is analyzed in this article. This decision held an insurance company liable in a wrongful death action for "negligently" issuing life insurance policies to a beneficiary who had no insurable interest (under Alabama law) in the life of the insured and who subsequently murdered the insured. This decision could have a far-reaching impact on insurance companies. It is for this reason that a careful reading of this article is recommended.

The author's principal attack is on the insurable interest approach underlying *Weldon*. He begins with this citation from *Grigsby v. Russell* (222 U.S. 149, 154): "a contract of insurance upon a life in which the insured has no interest is a pure wager and gives the insured a sinister counter interest in having the life come to an end." Finding nothing in the anti-wagering rationale which would aid the court in supporting a tort action, the author goes on to discuss in detail his reasons for rejecting also the anti-homicidal rationale. This analysis, together with the briefer discussion of foreseeability, merit close study by all insurance counsel. Also of interest is his suggestion of substituting a "consent" approach (i.e., protecting the insurance company from tort liability when the insured's consent had been obtained to the company's issuing of the policy) for the "insurable interest" approach of *Weldon*. Duesenberg, Insurer's Tort Liability for Issuing Policy Without Insurable Interest—A Comment, 47 Calif. Law Rev. 64-73.

California Law Review, Inc.
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COMMENTS:

The titles of some of the more interesting comments are listed below for the lawyer who may have the problem in his office:

*Damages*

1. New Hope for the Defense—The Rule of *Botta v Bruner*, 61 West Va. Law Rev. 302-5, (West Va. Univ. College of Law, Morgantown, W. Va.).

2. A Modern View of Wrongful Death Recoveries: Herein of the Infant and the Aged. 54 Northwestern Univ. Law Rev. 254-63 (Northwestern Univ. School of Law, Chicago 11, Ill.).

*Insurance*

3. Effect of Presumption of Death after Unexplained Absence upon Life Insurance Policies, 61 West Va. Law Rev. 298-301. (West Va. Univ. College of Law, Morgantown, W. Va.)

4. Liability in Excess of Policy Limits for Failure to Accept a Reasonable Offer—Refusal of Insurer to Defend, 11 Ala. Law Rev. 303-320. Univ. of Alabama School of Law, University, Alabama)

*Negligence*

5. Agency—Automobile Tort Liability of the Minor Principal, 47 Ky. Law Jour. 545-50. (Univ. of Kentucky College of Law, Lexington, Ky.)

6. Wrongful Death Actions as Affected by Parent-Child Relationships, 11 Ala. Law Rev. 331-7. (Univ. of Alabama School of Law, University, Alabama)

7. Imputed Contributory Negligence, 26 Tenn. Law Rev. 531-48. (Tennessee Law Rev. Ass'n, Inc., 1505 W. Cumberland Ave., Knoxville, Tenn.)

8. Pre-Natal Injuries: Damnum Absque Injuria, 26 Tenn. Law Rev. 494-513. (Tennessee Law Rev. Ass'n, Inc., 1505 W. Cumberland Ave., Knoxville, Tenn.)

## WRITINGS OF LOCAL INTEREST:

*California:*

Standardized Jury Instructions in California, 5 St. Louis Law Jour. 347-56. (St. Louis Univ. Law Jour., 3642 Lindell Blvd., St. Louis 8, Mo.)

*District of Columbia:*

A Survey of the Hearsay Rule and Its Exceptions in the District of Columbia (Part III), 48 Georgetown Law Jour. 145-169. (Georgetown Law Journal Association, Washington, D.C.)

*Florida:*

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# The Impact on the Casualty Insurance Industry of Recent Developments in the Personal Injury Litigation Field*

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MAY I first express my appreciation for this opportunity to discuss with you a topic of major importance not only to the legal profession and to the insurance industry, but to our society as a whole. It is not my expectation that I will evolve a solution to the problems before us. I do hope that I may be able to focus your attention upon problems which merit your most serious thought.

First, you should know who I am and the capacity in which I appear before you. I am one educated in the law, who, early in his career chose to cast his lot with the insurance industry. For more than twenty years, time out only for military service, I have worked in the employ of the companies of the America Fore-Loyalty Group, expending most of my efforts in the casualty claim field. I appear before you as an individual, not as a representative of my companies or of any trade association with which my companies are affiliated. The views which I express here are my own.

The program has told you that I am to talk with you about the impact upon the casualty insurance business of recent developments in tort law. Let us first recall to mind what insurance is. In its simplest sense it is an economic device whereby the risks with which each member of a society is faced are spread over many people. It has been said that it is a device whereby a loss unbearable by one, may be shared by many, in consequence of each having contributed in small part to the anticipated losses of the group. In today's discussion we are concerning ourselves with but one field of the insurance business—liability insurance. Liability insurance is designed to protect the policyholder against loss arising out of his legal liability to others for injury to the person or property of others.

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There are certain conditions precedent to the establishment and maintenance of a sound insurance venture. First, there must be a risk and by a risk I mean a possibility of loss which makes for a certain insecurity on the part of the person who faces that possibility of loss. Second, the relative probability of a loss occurring must be predictable with reasonable accuracy. Third, the quantum or the probable amount of the loss must be predictable with reasonable accuracy. Only if we can identify the risk, know the probable frequency of loss and know the probable monetary value of a typical loss can we predict the total economic loss to be suffered by any given group of people and formulate rates or charges for insurance protection which give a reasonable likelihood of continued solvency of that venture which is willing to undertake the risk.

Let us consider how these three conditions precedent apply to the casualty insurance business. The essential element of risk in the liability insurance field is the fact that our law imposes upon each of us certain duties, the breach of which with resulting damage, places upon us a legal liability to pay damages. If we are to iden-

tify with certainty the nature of the risk with which we are faced there must be a reasonable stability in the principles upon which the legal liability of the insured is established; the status of the law must be such that in any given set of circumstances we may be able to predict that the insured probably will or will not be held to be legally liable. As to the probability of loss occurring, that is, the element of frequency of loss, we must know that out of any given number of people who are faced with the risk or possibility of loss, a certain number will in fact be found to be legally liable. Finally, as to the probable amount of loss, we can predict with a reasonable degree of accuracy only if there is stability in the determination of the monetary damages which will be assessed against those found to be legally liable. This is but another way of saying that we must be able to predict with reasonable accuracy what a judge or jury will assess as the damages in the usual or statistically average case. If we confront casualty insurance with radical changes in the nature of risks, radical changes in the probability of loss, or radical changes in amounts of verdicts, we importantly affect the foundation of a sound insurance venture.

There is a final important consideration which must be borne in mind. Liability insurance operates to insulate the buyer, the public, against loss. As long as this insulating barrier is available, the public concerns itself but little with the heat and flame on the far side of the barrier; but if the cost of that barrier rises beyond the means of any large segment of the public, or if, because of inadequate rates, the insurance industry can no longer make available the insulating barrier, the typical member of the public will become aroused. He will direct a searching light upon all involved in leaving him naked before the fires of tort litigation. If he is satisfied that a metamorphosis in the law or its administration has placed upon him a burden which it is beyond his economic capacity to bear, he will demand a change in the rules out of which his burdens arise; if he finds that the theoretically available protection is not in fact available to him, he will demand a similar change. Regardless of the routes which he may follow, the typical member of the public will arrive at the same destination, an insistence that the law be so changed that he is no longer exposed to danger without protection.

Now let us move to this matter of recent developments in the field of personal injury litigation. Those of you who have studied this subject know that there have been few changes in the substantive law which properly may be classed as "recent." The developments with which we are concerned are characterized by a common thread which even superficial research can establish as running back through our law for half a century. What has happened in the recent past and seems to be continuing, is an acceleration of these developments, a speeding up of change, something which reminds us of some wild dance—the music becoming louder, more insistent in its rhythm, its tempo increasing as the dancers perform in wilder and wilder gyrations, giving promise of a climax shocking to all who observe. The opening notes of the overture were sounded before the outbreak of World War I and they sounded against a stage setting erected by Roscoe Pound. In January of 1914 Pound wrote an article entitled "The end of Law as Developed in Legal Rules and Doctrines."[1] In that article Pound traced the development of the law of torts. He spoke first of "The Archaic Law," in which the primary purpose of the law was the substitution for private vengeance and private war of a system of rules under which controversies could be adjusted peaceably. It was in this era that the plaintiff's right to compensation for injury done him by the defendant was absolute and was not a thing to be adjudicated in contemplation of the propriety of the defendant's conduct. Pound traced the development of the law through its second stage, which he called "The Strict Law"—one in which the end of the law was certainty, in which the manner in which the state would interfere in controversies between citizens was defined in utterly hard and fast ways. The rules were inelastic and inflexible. Then Pound came to the third stage of the law—a stage of liberalization, a stage which has been characterized as that of equity or natural law. He said that the outstanding ideas of this stage of development of the law were the identification of law with morals, the conception of duty, an attempt to make moral duties into legal duties, and reliance upon reason rather than upon arbitrary rule. Professor Malone of Louisiana State University has said of this development in the law, "It was

[1]Pound, "The End of Law as Developed in Legal Rules and Doctrines," 27 Harv. L. Rev. 195 (1914)

hailed by scholars and lawyers as the crowning triumph of reason and morality towards which the common law had been groping for centuries."[2] Pound then moved to what he characterized as "Socialization of the Law." Of this stage he said, "Its watchword is satisfaction of human wants and it seems to put as the end of law the satisfaction of as many human demands as we can . . . . . Today (1914) there is a strong and growing tendency to revive the idea of liability without fault . . . . . There is a strong and growing tendency where there is no blame to ask in view of the exigencies of social justice who can best bear the loss and hence to shift the loss by creating liability where there has been no fault." This was one of the early recognitions of the trend in American law to create liability without reference to fault.

At the same time that Roscoe Pound was writing, another of the great students of the law, Jeremiah Smith, was writing to the same subject.[3] In what has proved to be a remarkably accurate prediction of things to come, Smith examined the problems arising out of the then new workmen's compensation laws. He predicted that the incongruities between the common law and the workmen's compensation acts would lead to ultimate abandonment of the time-tested theories of tort principles and that eventually the principles of compensation regardless of fault would extend themselves into all claims arising out of accidents. Professor Smith doubted that there would be direct and avowed abandonment of the principles of tort law; instead he suggested that by indirect means the courts could subtly alter the law. He said, "By a very liberal construction of the res ipsa loquitor doctrine; by a broad view as to what constitutes prima facie evidence of negligence; and by inverting the burden of proof (putting on defendant the burden of proving that he was not negligent,) the courts could go far toward practically reversing the common law . . . . ."

Have such changes in fact come about? And if so, how? There have been statutory changes in the statement of the duties of the defendant; there have been the shiftings of the burdens of proof, perhaps most notable in the application of the doctrine of res ipsa loquitor to situations far removed from those in which the doctrine was first applied. There has been by court decision acceptance of the view that a determination of the financial ability of the defendant to respond in damages is germane to the adjudication of tort liabilities. There have been, by judicial interpretation, expansions of liabilities which historically were recognized but restricted in their application. And perhaps as significant as anything, there has been a remarkable growth in the reluctance of judges to hold that as a matter of law a given set of facts fails to satisfy the legal requirements of liability. The corollary result has been that more and more cases are going to juries. The importance of this phenomena was emphasized nearly thirty years ago by Edmond Morgan, Jr., when he said "It is a current forensic commonplace that a very effective method of destroying in action an unjust or unpopular rule of law, is to delegate its application to the jury."[4]

But you say these are generalizations and no more than my conclusions. You ask that I give you evidence to support the conclusions. Well, let us look at the evidence as seen in recent decisions.

One of the outstanding recent decisions is the *Bondex* case. Bondex is a cement base paint used principally to make masonry waterproof or water-resistant. Plaintiff, a twelve-year-old boy, was helping his father apply Bondex. In the course of the work, the boy's eye came in contact with the paint brush dripping with Bondex which was held by his father. The paint caused loss of sight of the eye. In an action against the manufacturer of Bondex, it was shown that on the Bondex box were printed cautionary instructions to the effect that the product contained cement and hydrated calcium oxide, which is lime, and that the alkalinity of the product would be irritating to tender or sensitive skins. In affirming judgment for the plaintiff, the Supreme Court of Missouri held that a jury question was raised as to whether there had been a negligent failure adequately to warn of the danger of getting Bondex in the eye.[5]

Another case of interest was a typical bottle explosion case. The plaintiff had suffered personal injuries as a result of the explosion of a bottled soft drink. In that

[2]Malone, "Damage Suits and the Contagious Principles of Workmen's Compensation," 9 NACCA L. J. 20 (1952)

[3]Smith, "Sequel to Workmen's Compensation Acts," 27 Harv. L. Rev. 235, 344 (1914)

[4]Morgan, "Some Observations Concerning Presumptions," 44 Harv. L. Rev. 906, 909 (1931)

[5]*Haberly v. Reardon Co.*, 319 S.W.2d 859 (Supreme Court of Missouri, 1958)

case the Supreme Court of New Jersey, upholding judgment for the plaintiff, sustained the application of the doctrine of res ipsa loquitor even though the bottle had passed through other hands after leaving the premises of the bottling concern.[6]

For a different type of case let us look at one which is perhaps well known in this part of the country, one involving the collapse of a derrick. The defendant manufactured an oil drilling derrick. It had been used for fifteen years without untoward incident when it collapsed, injuring the plaintiff. For years the courts had followed *Lynch v. International Harvester Co.*, 60 Fed. 223, which had held that the safe employment of equipment for five years precluded a finding that the equipment was negligently manufactured. So the trial court directed a verdict for the defendant on the ground that safe use of the equipment for fifteen years negated any probability that it had been negligently manufactured. But in 1958 the United States Court of Appeals reversed the trial court and remanded for a new trial, holding that prolonged safe use did not bar an inference of negligent manufacture.[7]

A case in another field was that of Roux Oil Shampoo. The plaintiff sued the defendant manufacturer of a hair tint alleging that she suffered from periarteritis nodosa, an inflammatory disease of the arteries, as the result of an allergic reaction to a certain coal tar derivative in the defendant's hair dye. The Supreme Court of Missouri commented that this was "The first instance in the history of law or medicine of periarteritis nodosa caused by allergic reactions to (the coal tar derivative.)" Yet the court affirmed judgment for the plaintiff.[8]

Particularly important is an emerging line of cases which broaden the duties of land owners and occupiers to trespassers. In Arizona we have a case involving injury to three boys, aged 11 to 16. While hunting, two of the boys trespassed upon the defendant's land. On that land they came upon a magazine in which explosives were kept. From that magazine they stole a box of dynamite detonator caps and removed it from the defendant's land. Later, with another boy, they set fire to the caps and all three were injured in the resultant explosion. The appellate court held that the case properly fell within the attractive nuisance doctrine and that the landowner had a duty to foresee the actions of the trespassers.[9]

It may be of interest to you to know that I was working on my notes for this part of my talk with you while my twelve-year-old son, Jim, was in the room and he listened as I dictated. Having heard my comments on this case, his spontaneous reaction was that he certainly would not have given anything to those boys because they shouldn't have been trespassing in the first place and they shouldn't have stolen anything in the second place. I suppose the basic difficulty with my son is that he has been too close to the teachings of his Sunday School to reconcile the conflict between standards of proper and improper conduct as he is getting them from the Scriptures, and proper and improper conduct as it is coming from our courts.

Another case illustrative of this trend in the law also came to us from the State of Arizona. This was an action by a father for the death of his eleven-year-old son. The father worked for an electrical cooperative. The boy frequently came to the premises of the cooperative to meet his father. While on the premises with the knowledge of his father, the eleven-year-old boy undertook to climb an automatic circuit breaker. He came in contact with energized circuits and was killed. The appellate court, upholding a judgment for the plaintiff, ruled that the jury properly applied the attractive nuisance doctrine to the facts, and not only held that the defendant should have anticipated that children might climb the circuit breaker to a point of danger, but exonerated the father from contributory negligence.[10]

In Pennsylvania there was a case involving the drowning of two children, aged 9 and 6. The City of Reading had an easement on certain lands. Upon those lands there were dispersed the waters from the city's storm sewer system. A pool formed and in the course of the winter the water in the pool froze. The two children, trespassers on the property, went out upon the

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[6] *Bornstein v. Metropolitan Bottling Co.*, 139 A.2d 404 (Supreme Court of New Jersey, 1958)

[7] *Pryor v. Lee C. Moore Corp.*, 262 F.2d 673, (10 Cir., 1958)

[8] *Braun v. Roux Distributing Co.*, 312 S.W.2d 758 (Supreme Court of Missouri, 1958)

[9] *MacNeil v. Perkins*, 324 P.2d 211 (Supreme Court of Arizona, 1958)

[10] *Downs v. Sulphur Springs Valley Electric Cooperative*, 297 P.2d 339 (Supreme Court of Arizona, 1956)

ice, the ice broke and they fell into the water and were drowned. Affirming judgment against the city, the appellate court held that the city had negligently permitted a dangerous condition to exist on land it controlled, without seeking to protect foreseeable child trespassers.[11]

Back in the woods on the country propon which I live there is a natural depression. Sometimes water gathers there in the late fall and freezes in the winter. Around most of my acres there are fences but I have found it impractical to hold the fence line intact against hunters on my woodlot so I have no more than posters prohibiting trespassing in that area. I must confess a certain apprehension lest, unbeknownst to me, children come through the woods from a side which is beyond my vision, attempt to cross the ice, and fall in. I wonder—does society truly feel that I should erect a cyclone fence to secure against this possibility of trespass by children?

In another interesting case that arose in Missouri, the plaintiff fell when he stepped on a defective stone slab on the defendant's place of business and suffered a fracture of the fibula of the right leg. Some eleven months later after the cast had been removed, crutches had been used and discarded, and the plaintiff had been advised to bear weight on the leg and ankle, while walking without the assistance of crutches or cane, he stepped from the ground to a porch some seven inches above the ground, placed his weight on the right ankle and the ankle failed. In the resulting fall he broke his left ankle. He sued the defendant to recover for the injury to both ankles and a verdict for the plaintiff was returned. In affirming judgment of the lower court, the Supreme Court of Missouri held that the evidence was sufficient to support a finding that the second fracture was a natural and proximate consequence of the same negligent act which caused the plaintiff's first fall and fracture.[12] Parentheticall-y, may we ask whether a jury case arises every time this plaintiff here after, throughout the remainder of his natural life, turns either ankle? Perhaps the statute of limitations starts running anew each time there is a new injury allegedly arising out of the original negligent act.

And from Georgia we have a case involving injury to an infant. In this case the infant's father was going into a bakery shop. He decided that the smart way to carry his nine-month-old child was up on his shoulders. He entered the shop and walked his child into an overhead electric fan. Action was brought against both the bakery shop lessee and the lessor of the premises for the resultant injuries to the child. The trial court sustained demurrers as to both defendants. On appeal the intermediate appellate court reversed as to both demurrers. The case then went to the Supreme Court of Georgia which sustained the intermediate appellate court, holding that in the circumstances the injured child was an invitee. The case went back for trial before a jury to determine whether the defendant had extended to this invitee the degree of care to which it was entitled.[13]

A California case involved poliomyelitis. An infant plaintiff was the victim of bulbar poliomyelitis which first manifest itself some fifteen days after an accident which had occurred in the backyard of the plaintiff's home, premises rented by the child's parents from the parties defendant in this action. These premises, along with others in the immediate neighborhood, were served by cesspools. The cesspools were relieved by a sump. Some of the sump water drained into the backyard of the plaintiff. The four-year-old child fell into the water. It was shown that there are many ways polio may be transmitted; there was *no* showing that there was any polio virus in the cesspool water into which the plaintiff fell. From a judgment for the defendants the plaintiffs appealed. The District Court of Appeals in California reversed, holding that there was presented a jury question as to whether there was a causal connection between pumping the water on the plaintiff's land and the contracting of polio by the child.[14]

Another case involved the doctrine of res ipsa loquitor. In this case the plaintiff was injured when she fell from a roller coaster in an amusement park. Judgment originally was for the plaintiff, but on intermediate appeal there was a reversal. On ultimate appeal, the intermediate appellate action was reversed and among other things, it was held that res ipsa loquitor was applicable in the case. As far as I

[11] *Cooper v. City of Reading*, 140 A.2d 792 (Supreme Court of Pennsylvania, 1958)
[12] *Bowyer v. TE-Co., Inc.*, 310 S.W.2d 892 (Supreme Court of Missouri, 1958)
[13] *Anderson v. Cooper*, 104 S.E.2d 90 (Supreme Court of Georgia, 1958)
[14] *Wardrop v. City of Manhattan Beach*, 326 P.2d 15 (Cal. App., 1958)

know, this is the first time the doctrine of res ipsa loquitor has been extended to a case in which a plaintiff fell from a roller coaster.[15]

And then, of course, there is one of the most widely discussed cases in recent years —the cancerophobia case which arose in New York. In this case the plaintiff was suffering from a bursitis in the shoulder. In the course of the treatment for the bursitis, she received x-ray therapy from doctors who were the defendants in this action. From the x-ray therapy she sustained a radio-dermatitis. She consulted a dermatologist who, after routine treatment, advised her to have her shoulder checked every six months because of the possibility that cancer might develop. Now the fact is the plaintiff never developed cancer, but the basis of her suit was that she became apprehensive about the possibility of cancer. So she brought a malpractice action against the two doctors who had originally treated her bursitis. The jury returned a verdict of $25,000 of which $15,000 was for the cancerophobia. Our highest court in New York held that recovery for the mental suffering arising from information which the plaintiff received from the dermatologist was justified.[16] I predict that the consequences of this decision by our distinguished Court of Appeals will be more far-reaching than any case reported in recent years.

In this entire area of actions based upon emotional disturbances perhaps the most notable case was the one involving the man whose ego was deflated. There was an automobile accident out of which there arose a spectacular fire and serious injury to several people directly involved. The plaintiff witnessed all this and had a desire to go to the assistance of the injured people but he was *afraid* to go to their assistance. Out of this fear grew a most interesting law suit. This witness to the accident filed suit and the theory of his suit was as follows: He had always thought himself a brave man but when this accident happened he found out that he was not as brave as he thought he was, and the sudden realization that he was not so brave came as a great shock to him. He was emotionally disturbed by this realization and in consequence of this sudden realization of his own inadequacy he embarked upon a new way of life. He changed his job and went into a new business field and even went into the field of politics. It was shown that he doubled his income in his new job but his medical witnesses testified that this pursuit of new business ventures was but an indication of the depth of the injury to his ego and promised of evil consequences to follow. The federal district court allowed this case to go to the jury and the circuit court of appeals affirmed.[17]

And the final case, which I think is truly an unique one, is the *Liberty National Life Insurance Company* case decided in Alabama. In that case the life insurance company issued policies on the life of a two-and-a-half-year-old girl. The primary beneficiary was an aunt, a contingent beneficiary being the child's mother. The aunt murdered the child. The father of the child brought an action against the life insurance company. Affirming judgment on a jury verdict of $75,000, the Supreme Court of Alabama held that there was presented a question for the jury as to whether the life insurance company was negligent in issuing life insurance policies on the life of the decedent in which the beneficiary had no insurable interest, and that whether such negligence was the proximate cause of the child's death at the hands of the beneficiary was a question for the jury. In effect, the Supreme Court of Alabama said that an intervening criminal act may be found to be foreseeable and if foreseeable, a failure to foresee may form the basis of an action in tort.[18]

A summarization of the import of development such as these was excellently given in an article written by Wex S. Malone of Louisiana State University.[19] Malone said, "Here in America a frontal attact upon the requirement of negligence would not become necessary until we have completely exploited the possiblities of using the jury as a foil. In cases where the plaintiff is unable to muster up more than a possible suggestion of negligence, the court can nevertheless submit the case to the jury and depend upon the jurymen to ignore largely the issue of fault, particularly if the defen-

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[15] *Kahalili v. Rosecliff Realty, Inc.*, 141 A.2d 301 (Supreme Court of New Jersey, 1958)

[16] *Ferrara v. Galluchio*, 152 N.E.2d 249 (N.Y. Ct. App., 1958)

[17] *Clegg v. Hardware Mutual Casualty Co.*, 264 F.2d 152 (5 Cir., 1959)

[18] *Liberty National Life Insurance Co. v. Weldon*, 100 So.2d, 696 (Supreme Court of Alabama, 1957)

[19] Note 2, *supra*.

dant is insured or is otherwise able to stand the loss by reason of his prosperity."

So much for indications of the changes in concepts of duties. Now let us explore a different class of development, one having to do not directly with substantive rights of the parties litigant, but a development having to do with the tactical advantage which one party to tort litigation may have.

It has not been so many years since most of us agreed that disclosure that the defendant was insured was prejudicial to the having of a proper trial of a negligence action. It generally was believed that evidence of a means of protection against pecuniary loss which the defendant might have had no relationship to the merits of a tort case. Yet, in no less than eight states the defendant in a tort suit is being required to disclose at pre-trial or in answer to interrogatories the fact that he has insurance and the limits of his insurance coverage. California, Colorado, Illinois, Kentucky, New Hampshire, Tennessee and Utah have so required. The essential rationale running through these cases seems to be that liability policies inure to the benefit of every person who may be injured by the insured. In this development, we have the courts openly and frankly saying that they are no longer interested only in questions of liability and damages, but are also interested in the economic capacity of the defendant to respond in damages if he is found to be liable. We see the emergence of a concept that the decision in negligence litigation should not be based alone upon a scrutiny of the conduct of the parties and the rules of tort law applicable thereto.

Other examples of changes giving tactical advantages to the plaintiff are to be found in some interesting legislation recently enacted in the states. At the last session of its legislature, the state of Connecticut adopted a law which provides that any release taken in a bodily injury case within fifteen days of the date of the allegedly tortious act is voidable at the option of the releaser. Mark you well that the release is not voidable if it was taken under circumstances out of which there might arise a reasonable presumption that the person taking the release had overreached the injured party. This statute makes the release voidable simply on the basis of its having been taken within fifteen days of the commission of the act out of which the injury arises. Anyone experienced in the field of negligence law knows that the great majority of injuries arising out of accidents are relatively minor and that the nature and extent of the injury can readily be determined shortly after the accident. In many such cases, an assessment of liability and damages can be made in a week or ten days. Truly, if we are interested in the prompt disposition of claims, we should accomplish quickly the disposition of this class of claims. I think that very properly there may be asked the question, "Was the enactment of this legislation motivated by the public interest or by the selfish interest of those attorneys who want to be assured of adequate time to get their hands on prospective tort litigation?"

Another example of this type of legislation is a law passed in North Carolina. That statute provides for the assessment of attorneys' fees upon any judgment of less than $500. Interestingly enough, it carries no provision for the assessment of attorneys' fees to the defendant if a defendant's verdict is returned. Here again may we not ask whether this legislation was sponsored by one having in mind the public interest, or only in giving to the plaintiff a tool for the harrassment of the defendant?

Let us look at the state of Vermont where we now have on the books a law which provides that actions may not be consolidated for trial except with consent of all parties and this includes counter-claims. Can it seriously be said that the proponents of this legislation are interested in simplifying the administration of justice, that they are interested in the prompt disposition of controversies, that they are interested in having before the court all evidence bearing upon the controversy? I think not. I think the proponents were interested only in the preservation of partisan advantage regardless of the effect which that preservation might have overall on the administration of justice. I am quite certain that in Vermont we will see instances in which each driver in a two-car collision will recover from the other.

Moving now from the area of legislative enactments, let us examine some relatively recent developments in trial techniques in the field of negligence litigation. At the outset let me say that I have always believed that the proper function of the jury is to determine questions of fact and that questions of fact are best determined by the objective presentation of evidence.

I believe that in the darkness in which the search for truth is conducted little light is shed by the flames of passion and aroused emotion. Yet under the beguiling title of "demonstrative evidence" we have seen developed to a high art a technique which in candor we must all admit has but one purpose and that is the arousing of the passions of the jury. Any person qualified for jury service is well aware of what is involved in the amputation of a leg, yet we see certain of our colleagues at the bar pointing with approval to the much-publicized Melvin Belli act of carrying into court for many days during the course of a trial, an artificial leg wrapped in a piece of butcher's paper. We see viewed with approbation the exhibiting of color photographs of unhealed wounds, and of plastic and wax bodies. As one author has said, "When juries, unversed in the law, are hypnotized by (these) techniques . . . ., they magnify in their minds the culpability of the defendant, and see him as the perpetrator of a reprehensible crime"[20] No honest man will debate the purpose of this type of evidence, yet we find these techniques being approved.

And then there is another technique—a technique employing the blackboard. Blackboards may have their proper place in the courtroom, but I ask you: If I were trying a case against you and in response to a question to a witness elicited an answer that was favorable to my cause, would you permit me to ask the question twice, or three times, or four times, so that the answer might reach the jury again and again? Of course you would not—you properly would object. Now I ask you to distinguish in principal between repeating the question and eliciting the helpful answer again and again, and my writing the answer on the blackboard and letting it stand before the jury for five, ten, fifteen or twenty minutes. I submit that the principle is the same, yet there are many who see no impropriety in placing evidence of special damages on a blackboard and letting it stand before the jury.

Related to this technique is another one —the technique by which plaintiff's counsel assigns a value to each day or week or month of alleged pain and suffering not yet experienced, or each period of anticipated humiliation because of disfigurement or physical limitation. This figure is presented to the jury with the request that it be used as the basis for determining the total damages which should be given to the plaintiff. I have always thought that it was proper to argue to the jury only those matters which have been put in evidence. You could not get into evidence testimony relating to the per diem value of pain and suffering or humiliation and yet we see this development in the law, the condoning of this device to get into the minds of the jury something of which there is no evidence in the trial.

One final development in tort litigation is the development in the pre-trial conference. Most thinking people see the wisdom of a pre-trial conference which narrows the issues to be tried but, in all too many jurisdictions today, pre-trial conferences have degenerated into a bargaining arrangement in which plaintiff and defendant appear before a judge who might better be called "the chief adjuster." Chiefly interested in how much has been offered and how much is demanded, the judge undertakes to close a bargain. Has the art of advocacy become so rare that the bar would now ask this of the bench—that it become black-robed hagglers in the market place? And will the bench long continue to so conduct itself?

Do these things of which I've spoken constitute radical changes in the nature of the liability risk which my industry would insulate you against, and do they threaten not only my industry but the very foundations of tort law as we know it. Listen to Flemming James of Yale University Law School: "No one seriously questions that one major trend in American tort law today is towards greater assurance of compensation to accident victims, . . . . . It is obvious that the fault principle—the insistance that there be negligence or something worse as a basis for liability—stands as a barrier to a thorough-going system of compensation in accident cases. It is not surprising, therefore, that recent times have witnessed a growing dissatisfaction with the limitations of the fault principle . . . and an increasing number of exceptions to it and distortions of it. This process of erosion is now well under way . . . ."[21]

One development which we have not

[20] Murphy, "Observations on the Future of Insurance, Awards and Compensation," Remarks at the Institute on Personal Litigation, Southwestern Legal Foundation, Dallas, Texas, 1952

[21] James, "Inroads on Old Tort Concepts," 14 NACCA L.J. 226 (1954)

discussed is that of increase in the cost of disposition of the individual claim. All who are interested in negligence law know that claim costs have increased spectacularly in the last ten years. When NACCA started publication of its journal its editors evidently decided that a verdict of $50,000 or more was sufficiently unusual that special note should be made of it because it devoted a special section of its publication to such cases. Now, such recoveries are fairly commonplace. Today we must get well up in six digits before we begin to attract particular attention. And the end doesn't seem to be in sight. Anyone in the negligence field must know that verdicts directly affect the settlement value of cases which are not tried. It is the verdict which is the yardstick against which the unsettled claim is measured. To pretend that verdicts do not affect losses and that losses, in turn, do not affect insurance rates is folly—you just can't change the facts. What are the facts? Don't take my word—look at the facts as published by the New York Insurance Department.[22] The largest—and perhaps from the public interest standpoint the most important—liability line today is the automobile bodily injury line. The New York state published figures show that the combined stock and mutual aggregate countrywide results in this line for the last three calendar years were as follows:

| *Year* | | *Underwriting Loss Sustained* |
|---|---|---|
| 1956 | | $109,276,660.00 |
| 1957 | | 205,451,728.00 |
| 1958 | | 166,528,623.00 |
| | Total | $481,257,011.00 |

That is a measure of the economic implications of the changes we have discussed. There is a limit to the capacity of any industry to absorb such losses. And there is a limit to the economic capacity of the buyers of insurance to absorb such losses. Is it any wonder that alternative methods of dealing with the personal injury case are arousing more and more interest?

Which brings me to my final point. It is a fact that the developments which we have discussed here have combined to make recent years among the most critical ones the casualty insurance industry has experienced. Knowing that we cannot indefinitely face present conditions and continue to provide the insulating barrier of protection which the public needs under our traditional system of tort law, we have tried to tell the public what is happening. We have attempted to discharge our obligation to inform the people to whom we have provided protection, and, to my amazement, we have found that our most zealous adversaries are lawyers. From coast to coast and from border to border there has come from spokesmen for the organized plaintiffs' lawyers a deluge of articles and speeches designed to discredit the insurance industry. Addressing the public, the bench and their fellow lawyers, these lawyers have said that we of the insurance industry have deprived the public of that which it is due, that we have concealed our true financial position, that we are making profits when we claim to be losing money, that if, in fact, we are losing money it is certainly not because of the changes in the law, trial techniques or higher awards.

Let me give you from the press some examples of the things which I speak of. I ask you to consider them dispassionately, objectively, and ask yourself whether these statements are true and in the public interest.

In Iowa insurance people were trying to explain to the public why their insurance rates were increasing. NACCA Law Journal accurately described the activity as an "attempt to make the audience conscious of the fact that automobile insurance is regulated by the number of automobile accidents in their own streets, in their own communities and the cost of those accidents by settlement and jury verdicts is reflected in the local rate level." I repeat—I characterize this as an accurate description of the activity. This activity was branded by NACCA Editor James G. McDowell, Jr., of Iowa, as "reprehensible" and he complained bitterly to the State Insurance Commissioner.[23]

In 1957 the Superintendent of Insurance of Florida granted a rate increase in Dade County. For this, according to the press, he was accused publicly by Mr. Perry Nichols of Florida, then national president of NACCA, of being a "rubber stamp" for insurance companies.[24]

The figures published by the New York Insurance Department[25] show that in 1957

[22] "1958 Loss and Expense Ratios," N. Y. Insurance Dept.

[23] 18 NACCA L.J. 455 (1956)

[24] Miami Herald, Sept. 18, 1957

[25] Note 22, *supra*.

the insurers writing automobile bodily injury insurance suffered an aggregate underwriting loss on that line of business of over $200,000,000, yet in January, 1958, Mr. Albert Averbach of New York State, formerly a governor of the second circuit of NACCA, wrote of insurance rates ". . . . the public should be made aware of the true facts that such increases if needed at the present time are due to increases in administrative costs . . . . . and not as charged because of high jury verdicts."[26]

In 1958, Henry Arnold Peterson, member of the NACCA board of editors from the state of Washington, addressed the Tacoma, Washington, bar association. He is reported to have said, "Losses for insurance do not come from higher verdicts or verdicts at all . . . . it is an insult to the courts of this state to try to blame high verdicts . . . . for insurance rate increases."[27]

Writing for the publication of the New York State Association of Plaintiffs Trial Lawyers in April, 1959, Mr. Joseph L. Rudell said, "Are large verdicts responsible for increases in insurance premiums and are juries to blame for losses incurred by some insurance companies? The answer is definitely no and the claims of the insurance companies to that effect are just so much hogwash."[28]

And in West Virginia last summer there were rate increases for automobile insurance. To the daily press of Charleston, West Virginia, a member of the board of governors of the West Virginia Plaintiffs Bar Association, Mr. John J. Lane, is reported as saying that insurance company figures are misleading. "No matter how many screams you hear from (insurance companies) their assets are multiplying. Why? It's simple. They don't declare the earnings on motorists' money they collected and invested."[29]

To Mr. Lane and his friends who echo him, I say that statements of insurance companies are published in a form and detail prescribed by state regulatory authorities. The comprehension of them may well be beyond the abilities of self-appointed experts like Mr. Lane, but they aren't misleading. The detail of their disclosure is overwhelming, but they are not misleading to those qualified to analyze them. And as for the matter of earnings on investments, one question. If for reasons beyond the control of policyholders, our investment return declines, should we increase rates? That's the corrollary of asking that investment gains offset underwriting losses.

And one last quotation—On August 14, 1959, Mr. Alfred S. Julien, retiring president of NACCA, said to the NACCA convention assembled in Miami: "Through numerous speakers and articles we are telling the public that verdicts have no impact on the premium dollar of which only 51% goes to the payment of claims."[30]

Where Mr. Julien got his figure of 51% I don't know, but I do know that by reference to government-published figures[31] he could have found that the automobile bodily injury incurred losses for stock companies in 1958 was 66.9% of the premium earned and that expressed in dollars, the incurred losses were over $145,000,000.

But let us stand back from this disordered scene and look for some discernible pattern, some evident path along which the characters are moving. In the picture we see broadening concepts of duties placing upon the defendant ever greater responsibility for the welfare of his neighbors and strangers as well. We see a well-organized, articulate army of lawyers bearing the lance of the plaintiff, zealously pressing still heavier burdens upon the shoulders of the defendant and demanding greater and greater retribution. Between the defendant and the plaintiff there stands the casualty insurance industry, the bearer of the shield by which the defendant has protected himself against the economic loss which the plaintiff has visited upon him. The insurance industry warns insistently that it cannot long continue to bear the shield in the face of the onslaughts of the plaintiff, but the plaintiffs' bar derides and discredits the insurers, calculatedly raising in the minds of all who hear question as to the honor and integrity of the insurance industry. From the background there advances with ever-quickening pace another figure. Upon his standard is the inscription "Compensation Regardless of Fault." His squires and grooms are named "Limited Recovery For All," "Closely Regulated

[26]Averbach, "A NACCA Lawyer's Views on the Casualty Insurance Industry," 420 Insurance Law Journal 19 (January, 1958)

[27]Weekly Underwriter (May 17, 1958)

[28]Rudell, "Excessive Verdicts or Excessive Propaganda?" The Plaintiffs' Advocate, Vol. 3, No. 1, Pg.25 (April, 1959)

[29]Charleston, W. Va. "Daily Mail," (August 13, 1959)

[30]Julien, "The Public's Lawyer," The Plaintiffs' Advocate, Vol. 3, No. 2, Pg. 19 (October, 1959)

[31]Note 22, *supra.*

Attorneys' Fees" and "Removal of Tort Claims From The Courts." His coming was foretold by Roscoe Pound and Jeremiah Smith and his progress has been noted by Wex Malone, Flemming James and a host of others. The justice of his cause has been proclaimed in the name of Columbia University,[32] by college professors,[33] by lawyers[34] and by judges,[35] and, of late, his cause has been advanced by the Governor of California.[36] This figure advances upon a road made from the residue of the granite blocks called "Morality" and "Ethics" which were the foundation of our law, stones that are being crushed into shifting sands called by Pound "the socialization of the law."[37] We see the defendant threatened with the loss of his protective shield seriously considering embracing this advancing figure as his champion. We see the plaintiff impatient with delay in the courts, indignant at frequently receiving a smaller part of the recovery than does his lawyer, wondering if he, too, should seek shelter under the banner of this coming figure; and we see some insurance executives, wearied by the continuing drain of their resources, contemplating passing the shield to the advancing figure.[38]

How will it all end? I don't know. There is no crystal ball into which I can gaze, nor is there any oracle which I can consult. Seven years ago today, there stood on this platform Ray Murphy who was then general counsel for the Association of Casualty and Surety Companies. Having reviewed developments in the law, Murphy said: "All this may seem to paint a Utopian picture for the plaintiffs' lawyer —it may be only a mirage. One realistic element is lacking in the phantasy— an inexhaustable and ever-present source of funds. Since insurance companies are not and cannot be such a source, and since no such source exists, the trend toward higher and higher payments, to more and more persons, in my opinion can but bring about the disintegration of our present system of jurisprudence."[39]

Ray Murphy's warning was ignored and the developments of which he told have continued. As an individual educated in the law, I am frightened by the things which I see before us. I am deeply disturbed at the prospect of our abandoning the moral and ethical foundations upon which our tort law has been built, for it is my deeply-held conviction that no society can but partly abandon principles of morality and ethics; either all of our conduct is governed by such principles or none is so governed. If there is hope of saving our heritage, it can lie only in the spirit of moderation which Judge Learned Hand once characterized as "the temper which does not press a partisan advantage to its bitter end, which can understand and will respect the other side, which feels a unity between all citizens—real and not the factitious product of propaganda; which recognizes their common fate and their common aspirations." Of this temper and faith, Judge Hand said, "They are the last flowers of civilization, delicate and easily overrun by the weeds of our sinful human nature. We may even now be witnessing their uprooting and disappearance until, in the progress of the ages, their seeds can once more find some friendly soil."[40]

The hour grows late. Perhaps generations to follow us will in retrospection see that even now we are irrevocably committed to the course. If there is any hope of avoiding these things, that hope must rest with the legal profession. If you will understand that there is a limit to the economic burden which the defendant can bear and that in some jurisdictions we have already gone beyond that limit, perhaps you will see the critical need for and will exemplify that spirit of moderation of which Judge Learned Hand spoke. If, however, you blind yourself to these economic facts, if you press to the point where the way becomes even more difficult for the defendant, you will have produced compensation regardless of fault de facto,

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[32]Report, Committee to Study Compensation for Automobile Accidents, Columbia University Council for Research in the Social Services, (Feb. 1, 1932)

[33]Ehrenzweig, "Full Aid Insurance for the Traffic Victim," University of California Press (1954)

[34]Marx "A New Approach to Personal Injury Litigation," 19 Ohio St. L.J. 278 (1958); Bently, "Commission Trials," Journal of the State Bar of California, Vol. 34, Pg. 413 (July-August, 1959)

[35]Hofstadter, "A Proposed Automobile Accident Compensation Plan," New York L.J., (Feb. 24, 1954)

[36]Inaugural Message, Gov. Edmund G. Brown, (Jan. 5, 1959)

[37]Note 1, *supra.*

[38]"Pros and Cons of a California Automobile Accident Commission," remarks by Fred Drexler, Senior Vice President and Secretary, Industrial Indemnity Company, Los Angeles, Cal., (Oct. 14, 1959)

[39]Note 20, *supra.*

[40]Quoted at page 1415, "The Practical Cogitator," Curtis and Greenslet, Houghton, Mifflin Co., (1953)

if not je jure. In such a situation it will be no great task to formalize the change.

I would leave you with a proverb—the proverb of the wise man and the cynic. It is told that a cynic said that he would fool a wise man. He said, "I shall go to the wise man with a bird in my hand and I shall say, 'What have I in my hand?' The wise man will say, 'A bird.' And I will say, 'Alive or dead?' If he says 'dead' I'll open my hand and the bird will fly away. If he says 'alive' I will crush the bird and drop its still warm body in his hands." So he went to the wise man and he said, 'What have I in my hand?' and the wise man said 'A bird.' The cynic said, 'Alive or dead?' and the wise man said, 'As you will.'"

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# The Insurer's Choice: Prepare or Lose*

J. HARRY LABRUM
*Philadelphia, Pennsylvania*

VIRTUALLY every issue of every insurance journal today—and almost every bar journal—includes at least one article on how to save the insurers from the plaintiffs' lawyers.

It is getting monotonous and I believe people are getting a little tired of it. This is especially true of the insurers. They think they are as smart as the next fellow; and they don't think they need to be saved from plaintiffs' lawyers.

I think they are right. Most of them don't need to be saved from the plaintiffs' lawyers. They need to be saved from *themselves!*

They need to be saved from their narrow-gauge approach to the problem of how to investigate claims and prepare cases for trial.

I don't think I have to tell this group what I am driving at. I'm talking about the constant and continual cry from on high that "COSTS" are eating us up alive.—That "COSTS" must be kept down. Not a word about holding *verdicts* down—just costs. The idea seems to be, "Don't worry about the verdict;—we'll be glad to pay it, if it doesn't cost us too much to lose the case."

In other words, some insurers apparently would sooner pay $50 in costs and $10,000 in verdict, than $250 in costs and $5000 in verdict. The total outlay is almost 100% higher—but we cut down on the *costs,* so it was a good day for our side.

Now, what I have said and what I will say, to the extent that it may seem to be critical of insurers, is intended to be *constructive* criticism. Indeed, it is almost *self-criticism.* Because, ever since I was admitted to the bar, my firm has been closely allied with the insurers, in not only casualty and compensation matters, but in admiralty, surety, products liability and other fields. We have held the chairmanship of the American Bar Association Section on Insurance Law; we have always been and still are active in that section; in the Pennsylvania and the United States Chamber of Commerce Insurance Sections; in the Federation of Insurance Counsel; the International Association of Insurance Counsel; and the Association of Insurance Attorneys.

So it is all in the family. As long as these things must be said, better to have them come from within, rather than from outside.

I only hope that when I have finished you will feel a little more satisfied than the Irishman who said, "Well, it was a hell of a war but better than none at all."

Perhaps you will feel more like the little boy who wrote to his grandmother and said, "Thanks a lot for the necktie you gave me at Christmas. It was just what I wanted—*but not very much!!*"

Some speeches I have made to insurance groups have produced reactions of that kind. However, I think a lawyer owes it to his clients, and to himself, to point out the unpleasant truth and to suggest remedies for the faults he finds. So I have more than once told groups of insurers and their representatives that they simply must spend more money on investigation of claims; that they must dig out the real facts and *get them into the file*; they must *settle more* cases and *try fewer* cases. I

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*Delivered before The Self-Insurers Association, New York City, December 3, 1959.

have also told insurers that they must be more *selective* in sending cases to trial counsel; that a late settlement is an *expensive* settlement, especially if it comes at the court-house door—and, believe it or not, this still happens dozens of times every day. A few years ago we actually told one of our best companies that they had too many cases in suit, and that they simply had to review all the cases that they had *already* referred to us for trial and *settle every one they could.* This cost our firm money, of course. But it was the right thing to do. And I am sure that speaking as I do today is also the right thing to do, from your standpoint and from mine.

A few days ago, after attending a dinner, I was chatting with a friend of mine, who is the claim manager for one of the large old line companies in the Philadelphia area. During the course of our conversation, he made this remark: "Sometimes I think my company would rather pay $1000 for the settlement of a doubtful claim than spend $5.00 in mileage for an adjuster to properly investigate the case."

This statement is no doubt an exaggeration. On the other hand, it does reflect an attitude that has arisen within the insurance industry much too generally in the last few years.

In our practice we come face to face with this problem frequently. The field adjuster and the claim examiner must be harrassed by it almost every day.

It is a rare instance when any of the articles that I mentioned even suggests an attempt to correlate the *cost* of investigation with the *savings* thereby effected on casualty or compensation losses. The fact that the costs which are so severely criticized may have saved many times that amount of money by reducing losses, seems never to be suggested as a justification for the expense.

Today, some claim managers and other claim executives, instead of plying the business for which they were hired—that is, the investigation and adjusting of claims—seem to spend the major portion of their time analyzing the expenses of the claim department and trying to devise ways and means of reducing them. Little or no consideration is given to the *effect* of these expenses, and the overall saving to the company. An investigation costing $5000 might save the company a HUNDRED THOUSAND dollars but it would still appear only as a $5000 *expense,* rather than a *saving* of the $95,000. A legal fee, or doctor bill, or the cost of some timely motion pictures, any one of which may have saved the company thousands of dollars, is still listed only as an expense, and it is items like these that the company attempts to reduce, irrespective of the savings that may thereby be jeopardized.

I do not believe that we can safely continue with that attitude today, in view of the increased number of fraudulent claims; the increased cost of settlements; and the apparently endless increases in the amounts of jury verdicts.

All of these things, plus the so-called "liberal" attitude of our courts, make it crystal clear that our investigation and preparation must be better than ever before. Both judges and jurors are seizing every opportunity to give our money away, and we are not able to win cases in which routine investigation and preparation would have produced victory only a few years ago.

Therefore, if we are to meet these threats and control our losses, our expenses must of necessity increase.

Businessmen often say that they have to *spend* money to *make* money. Insurers have to spend money to *save* money. And a penny saved is still a penny earned. Indeed, it is more—because a penny saved is a penny *net.*

Still, the question is often asked, why spend all this money on preparation, especially when defendants' verdicts are so rare?

You all know the answer. The money has to be spent to increase the chances of obtaining either a defendant's verdict, or holding an adverse verdict to a fair amount. It must be spent, first, to find out whether the defendant is actually liable *at all;* second, if there is either *actual* liability, or, if a jury or a referee is likely to *find* liability, *how much* is the case really worth, how can we hold that verdict *down*?

Each of these points obviously presents an opportunity to save a good deal of money. Too often, however, even when the approach is right, the execution is frustrated by the lack of authority to take the necessary steps to do a thorough job and achieve the desired result.

"Keep down expenses"—that old bugaboo stares you in the face and the lack of

courage or authority to ignore it results in even higher verdicts and greater losses in the end.

What has brought about this attitude on the part of so many insurers? In retrospect, the picture looks like this to me: During the postwar period from 1946 to 1952, millions of new cars were being delivered each year to a car-starved public; insurance policies were being turned out in the same way; and the insurance companies were making money on this volume almost without effort. They gave little or no thought to costs. The premiums were rolling in, the so-called "adequate verdict" was not yet too high, and even if it went higher the premium income was sufficient to take care of it. The inflationary spiral was beginning, but its impact had not yet really been felt in the insurance field. God was in His Heaven, business was rushing, and everyone was happy.

Then, sometime around 1951 or 1952, expenses began to catch up with the premium dollar. The inflation spiral was definitely under way. The "more adequate verdict" was beginning to hurt. Then the insurers began trying to protect their profit margin by cutting down on expenses. The economy program began with personnel and continued through investigation and costs of every nature. The emphasis was laid on cutting expense—not on improving preparation, and thus reducing the cost of verdicts.

Simultaneously with this cutting down by the insurers, the plaintiffs' lawyers began the "build-up" in earnest. They began to spend money with abandon in the preparation and development of their claims, and in the schooling of their members in the trail of cases. The "more adequate verdict" soon became commonplace and the only question was "how much"? It was a rarity when a jury found for the defendant. The insurers continued to lose money and sought to correct the trend by cutting expenses to the bone, all of which further hampered the claim adjuster and the defense attorney. The lack of careful investigation in many cases prevented trial counsel from presenting the true factual situation to the jury and actually invited the "more adequate verdict" because the case seemed so one-sided to the jury. With each such loss, there were further efforts on the part of the insurer to cut down expense, and the vicious cycle was on in earnest. "Expense" became almost an obsession because it was something the insurer could control. The much higher cost of the verdicts themselves was considered to be unavoidable, on the theory that no one could control a jury.

When the insurer starts this talk about cutting expenses, what expenses is he talking about? He is, of course, talking about the cost of winning his case; that is to say, the cost of either defeating the claim altogether, or holding the recovery within bounds. The stake may be $5000 or it may be $500,000. The *costs* are infinitely lower than the possible *verdict* that depends upon the preparation those costs will buy. The costs are an *investment* which in most cases will pay big dividends. But, in many cases, either because of a general policy or a specific ruling, the investigative staff is not permitted to make that investment.

This phobia on costs is, in my opinion, and in the opinion of most experienced trial men I know, a glaring example of false economy. It is being penny-wise and pound foolish—and no insurer can afford to stay in that category.

The expenses that are often being disapproved are the price of the most important ingredient in any case: *PREPARATION* —and that ingredient must be put into the mix before—*long before*— the case is on trial. It must be bought and fed into the mix by the claims department—not by the trial lawyer. If you see any trial lawyer apparently pulling rabbits out of a hat at trial, you can be sure they were put in that hat in the first place by some alert claims man—with a few dollars to spend on carrots.

It is a pleasure to work on files like that and to try cases like that. But a *half-investigated* case makes the trial lawyer feel like the unfortunate horseback rider down south. This rider approached a swamp and asked a young boy standing nearby whether the swamp had a bottom. The boy said, "Sure", so the rider went ahead. But his horse soon foundered and the rider himself was up to his neck in muck. As he went down he screamed at the boy, "You said this swamp had a bottom", and the boy replied, "It has—*but you're not half way to it yet*".

When you step into a case that has been only half prepared, you know you're going down, but you don't know how far or how much it will cost your client. It

is a miserable and frustrating feeling. I tried to prescribe the cure a year or so ago when I was asked to speak at Vanderbilt University in conjunction with a seminar sponsored by the Tennessee Bar Association. Technically, my assignment was to discuss recent developments in the presentation of a negligence case from the defendant's standpoint. Now all of you are familiar with all these gimmicks, or so-called trial techniques, such as motion pictures, blackboards, charts, models, and so on, that are being used to persuade, and sometimes mislead, juries. In my talk, I expressed the view that all of these new techniques, gimmicks and devices, and the answers to them, could be described in just two words—"Better Preparation". I repeat that today. And I emphasize that I mean better preparation not only by the lawyer, but especially by the investigator. The prime importance of the investigator's role should be obvious. It is not uncommon for the trial attorney to see the file for the first time months or even years after the accident has happened or the injury has been incurred. Therefore, *the real preparation of the case rests with the claim agent or adjuster,* and not the trial attorney. Likewise, the outcome of the litigation often depends upon the ingenuity of the adjuster more than upon the cross-examining ability of the trial attorney.

Consequently, while we are criticising some insurers for their penuriousness about costs, perhaps it would be well to take a look at these claims men and adjusters from management's point of view and determine what part they may have played in bringing about the situation about which we are complaining. Just last week, when discussing the need for further investigation in a particular case with the general counsel of a large insurer, I was told that in a great measure this attitude resulted from the failure of the claim agent or adjuster to use discrimination in the selection of those cases which needed thorough and complete investigation and those cases which, after preliminary investigation, showed definite liability and should be adjusted and settled promptly.

This man cited as an example a case where the liability was clear and yet the investigation continued for such a long period of time, on matters not germane to the issue, that the opportunity for early and advantageous settlement was lost forever.

He also feels that there is a great deal of aimless investigation; that claims men and adjusters often lack decision; that the local claims men fail to get out quickly and investigate cases, and, where liability is determined, settle promptly. His view is that claims men and adjusters alike should come to a point of decision promptly as to whether to settle or try a case. When the determination is made, then the case should be thoroughly investigated if it is determined to try it and, if not, it should be settled promptly. It is his thought that if it was determined to try the case, it should be promptly referred to the insurer's counsel for examination and determination of further investigation; that in no instance with which he was familiar did any insurer refuse to pay the expenses of a further investigation; but that the tight rule on expenses was established only to keep a check rein on unwarranted expense and needless investigation.

I might say that he placed the major blame for this condition on the supervisory personnel. He said that lack of training of the local adjuster and lack of thinking by supervisory personnel were the primary causes of the insurer's attempt to control costs of investigations.

So there you have both sides of the story, and I am sure this conflict of opinion is not news to any of you.

In fact, of course, there is no real conflict. *Everybody* believes in adequate investigation and preparation. The dispute is in applying the agreed rule to particular cases. And that is where you claims men can make your greatest contribution. Because, as I see it, the most important attributes of a claim man or adjuster are (1) the ability to ferret out the real facts of the accident, (2) the ability to accurately appraise the damages, (3) the ability to negotiate a fair settlement if there is liability, and (4) by careful discrimination and decision to determine what cases should be settled and what cases should be tried.

In this way, the claims man will be able to assist the insurer in keeping not only the costs but also losses within reasonable limits. Even when the cost of proper and thorough investigation is going to be large, the adjuster or claim man should never hesitate to seek authority to spend

whatever sums are necessary to do a complete job. In making such decisions, he must, of course, discriminate between the unimportant and important or dangerous case, and should always take into consideration the nature of the case, the probable liability or non-liability of the insurer, the exposure, and other practical factors. There is a practical limit to the investigation of facts. The importance of the case must to some degree measure the time given to it. The initiative must come from the adjuster or claim man and once the decision is made he should be willing to fight for it with higher authority.

There should be strict supervision over men settling claims and quick decisions must be made by higher authority on raising their authorizations to settle. I believe in giving the claim man sufficient authority to make settlement in the normal case and, if he has been carefully selected and trained in the first instance, he will do the same kind of job in settling for less than his authority as he would if strictly limited.

Experience and knowledge must of course be coupled with backing from higher authority if the claim man is to make good settlements promptly.

Unless the facts in the case clearly afford a legal defense, claims men should not hesitate to make fair and equitable settlements and they should be authorized to do so. This does not mean that there should be a wholesale, indiscriminate settlement of cases. However, once the decision to settle is reached, the case should be promptly concluded if the claimant will accept.

If the company is not liable, the investigator should not hesitate to say so. He must remember, however, that *every* case is potentially dangerous and that he must not substitute wishful thinking for facts nor look at the facts through rose-tinted glasses. Especially if he is going to deny liability, he must support his opinion with the facts—the real facts—remembering that when the case comes up for trail his *opinion* will be worthless and the case will be lost unless he has the facts—*in the file*—not in his head.

Indeed, one of the chief causes of the high verdicts and large settlements at the courthouse door, is that the file does not enable those in authority to recognize and to settle serious claims before they get into the hands of a lawyer who will build up the case and get it to one of today's free-wheeling juries.

The man in charge of a claim department today must be able to recognize quickly the potentially dangerous claim as soon as he sees the adjuster's report and knows the area of the settlement value. He is charged with the responsibility of settling claims before they become suits. His success will depend to a large extent on the type of adjusters under him. They must be intelligent, experienced and possess a great degree of initiative as well.

In the negligence field, the courts have all but abandoned their function of establishing standards of conduct as a matter of law and all issues are generally given to juries as questions of fact. The insurers must face the realities of the situation and adopt a more aggressive policy to liquidate every possible claim. In all cases where the hazard of a trial is too great in view of the amount involved, the case should be settled, and settled as early as possible.

I do believe that, in this matter of paying for investigation and preparation, the pendulum is now beginning to swing a little in the direction of the claims man and the defense attorney. I believe the insurers are beginning to realize that the time has now come for them to at least match the efforts of the plaintiff's attorneys in investigation and in preparation. This of course means the expenditure of larger sums of money in investigation and in preparation, but the companies are beginning to see that this program will pay for itself, over and over again. Only better preparation, by the adjuster and by the defense lawyer alike, will discourage the plaintiffs' lawyers from taking the money gamble which is part of their stock in trade when shooting for a large verdict. I dare say that with proper investigation and preparation the number of defendants' verdicts will increase and plaintiffs' attorneys will be less likely to finance the questionable cases which have become the bane of the insurance industry.

Then again the psychological effect will be even greater as it will strengthen the hand of the adjuster in making fair settlements and will give pause to many of our judges who, in order to clear congested calendars, are bludgeoning lawyers into making settlements where no liability exists.

It is indeed time for the insurer and the defense lawyer to regain the initiative. No better basis can be provided than better investigation and preparation at both the adjuster and trial lawyer level. It is an investment that can bring relief to this sorely beset industry.

At this point, I would like to say that the trial bar generally *has* taken many measures to keep pace with the plaintiffs' attorneys and doctors. This is true not only with respect to knowledge of the law and trial techniques, but other fields as well. Most of our trial men today seem to be almost as well versed in medicine as they are in law. They are doing a fine job of counter-acting these new gimmicks as much as they can with the tools at hand. They are giving the plaintiff and his lawyers and his doctors a good run for their money. And, with more thorough preparation in the investigating stage, we can do even more towards getting the insurers the best possible result in any given case.

So far, I have been speaking largely of casualty cases. However, it is also true that in the field of workmen's compensation, many claims are not given the preparation they deserve. Some insurers' attitudes toward these claims seem still to be geared to the situation that prevailed under earlier compensation laws, when awards were small and of short duration, and great political power had not yet come into the hands of labor. Today our legislators rarely meet without in some way increasing the benefits payable under workmen's compensation. I believe it is safe to say that, at this stage of the game, the average compensation claim exceeds in value the old common law personal injury claim.

Compensation claims are being decided today by referees and commissioners whose sympathy for claimants seems to be directly proportionate to their desire to remain in office. Many of them are not qualiffied or equipped by education, experience or temperament for the function they are supposed to perform in an impartial manner.

Their judgment is too generally colored in favor of the claimant, irrespective of the merits of his case.

In the face of these facts, many of our insurers continue to apply the old methods. It is common to find, for example, that a company's compensation claims are handled across the "comp desk", which is administered by a clerk, freguently a woman, whose only experience is as a secretary or stenographer in the claims department, while the experience and talents of the claim manager and his staff are directed toward the onerous general liability claims. This, despite the fact that the problems now coming across the "comp desk" have become increasingly complex and expensive. An intimate knowledge of the compensation statute, its schedules of compensation, and the judicial interpretations thereof, is absolutely essential to the proper evaluation of a claim. This knowledge is frequently lacking. Without it, it is impossible to intelligently investigate, settle or defend any claim.

Many claims men and adjusters regard their compensation assignments as a sort of poor relation to the other claims in their assignment book. They approach them with disdain, sometimes with ignorance, and almost always with condescension. Frequently the investigation is limited to a form accident report obtained from the insured, or the foreman, and a form medical report obtained from the examining physician. Frequently the approach does not even include a dollar evaluation of the claim, without which intelligent cost consiciousness becomes impossible.

To give you an example of how lacking in impartiality some of the compensation tribunals can be, one of my associates recently handled a petition to terminate compensation payments to a claimant who had received payments for over a year for a back injury. The treating physician and the defendant's expert (both well qualified orthopedic surgeons) testified that the claimant had fully recovered and had no further disability. The claimant produced no evidence other than his own statement that "his back hurt". He admitted that he had not attempted to find employment. The referee concluded that he was *totally disabled.* At this point the insurer realized the potential of the claim and placed the claimant under surveillance, obtaining motion pictures showing him engaged in strenuous activities. Another petition was filed and termination has been accomplished, but he had already been paid over two years compensation which had accrued during the pendency of the first hearing. An appreciation of the potential value of the claim, coupled with a realization that we must present our defense in such a clear and convincing fashion as to leave no

doubt of the bad faith or misrepresentation on the part of the plaintiff, would perhaps have resulted in a much more careful investigation including surveillance at the outset, at a considerable saving in losses.

In another case one of our referees apparently could not make up his mind whether the claimant had or had not suffered a herniated disc. He therefore appointed an impartial orthopedist to examine the claimant and resolve the conflict. A well know plaintiff's doctor was appointed as the impartial. He testified that, for the first time in 40 years as an impartial witness, he had to go along with the defendant because he could not be convinced that there was a herniated disc since all the classic symptoms were absent. Not so, said the referee; and that is probably this doctor's last appointment, as an impartial. The referee awarded total permanent disability for a herniated disc. Again, surveillance is being carried out; but think of the cost to the insurer in the meantime. This is another reason why it is vitally important to promptly investigate and obtain all facts which tend to prove the invalidity of a claim.

Actually, the carriers in these examples cannot be criticized because the decisions were so outlandish as to be unforseeable even today. However, if the cases had been carefully investigated at the outset and followed up periodically by a competent claims man, the result might have been different. I mention these cases only to illustrate the point that the cards are stacked against the defendant to such an extent in this field that an early evaluation of the potential of a claim is essential, so that an investigation commensurate with that potential, and with the probable partiality of the tribunal, may be intelligently undertaken.

In another case, the claimant gave the adjuster a signed statement describing an accident and injury to his back which he suffered in his rented apartment. At the time he thought the adjuster represented his landlord's liability insurer. Later he testified at a compensation hearing that he had injured his back at work. When confronted with the prior statement he became flustered and stammered an explanation to the effect that he was behind in his rent and had claimed the injury happened at home to keep the landlord from demanding the rent. The defendant also introduced a hospital record on which the history indicated that the accident occurred at home. The referee nevertheless stated "there was a ring of truth to the claimant's story", and entered his finding for the claimant. The case was finally settled for a nominal amount.

In another case we represented an insurer where a termination petition had already been filed by the company. The clerk on the compensation desk failed, however, to notify the treating physican of the filing of the petition and he continued to treat the claimant for the entire year before the case came on for hearing. As would be expected, the doctor could not testify that the claimant was completely cured and the decision was partial disability which had to be paid until the company was in a position to demonstrate that disability had ceased.

Compensation cases can be won, but they must be prepared just as carefully as any other case. In years gone by, perhaps the amount in controversy would not justify such preparation. Now, however, an extensive investigation is warranted and is vitally necessary in most cases. Compensation claims should be closely supervised by trained and experienced claim men and should no longer be considered the "poor relation" in the claim department. They should be evaluated at the outset with whatever information is available or obtainable, and the heavy exposure of what can now be lifetime payments must be taken into consideration. Every adjuster should be carefully trained and should be permitted to follow his cases from beginning to end, so that he may understand the vagaries of the tribunal before which his cases are tried. *Average* preparation will not do. And if the facts justify, an overwhelming case must be made out which will convince the tribunal beyond doubt that the defendant should prevail.

The compensation desk should be raised to the dignity of a department and the same approach should be applied to the handling of compensation claims as is now applied in liability cases. Greater attention should be given to the type of person to be employed as a claim manager or adjuster. Carelessly selected, he can cost his employer untold amounts and bring disrespect to the insurance industry. Properly selected, he can save thousands of dollars for his employer.

For example, one of the companies which we represent in the Philadelphia area is acknowledged to have perhaps the highest paid staff of adjusters in the insurance industry. In addition, their men probably receive fewer assignments than the adjusters in any other company in our area, and this in spite of the fact that they have not one man in their employ, even as an adjuster, who has less than fifteen years experience. As a result, they have one of the lowest, if not the very lowest, loss ratio in the Philadelphia area and indeed in the entire country.

Today, of course, even proper and productive preparation will not guarantee victory. A few weeks ago I read in the New York Times about a suit against the City of New York by an individual who claimed to have been struck by a police car. The liability question hinged on the testimony of a disinterested witness. The disinterested witness testified that he saw the entire incident and he had all the right answers for the plaintiff. However, the claims man for that company did a thorough job of investigation, and counsel for the defense was able to prove that on the date of the accident, the disinterested witness was snuggly tucked away in jail. The trial, strangely enough, resulted *not* in a defendant's verdict, but a *hung jury*, again emphasizing that the defense must be better prepared and must not overlook a single possibility if it is to prevail these days.

I could give you innumerable examples of the increasing difficulty with which we are faced in obtaining even elemental justice in the trial of casualty and compensation cases. Yet, almost invariably, when anyone requests additional investigation to meet this increased burden, it is met with resistance. Whether this stems from the attempt of the claims man himself to keep down costs or from rules promulgated by higher authority may be open to debate. One thing is certain, however, and that is that insurers and claims men generally must be eternally vigilant and leave no stone unturned in their investigations if the defense is to prevail at all.

It has been suggested that I conclude my talk by giving my definition of a good claims man or adjuster. I believe I have already given you my ideas on this subject. However, let me add this: these men's basic function is the discovery of the *full facts* regarding each claim and the disclosure of those facts in a lucid report. This means careful observation and accurate reporting. It means prompt action. Investigations delayed mean increased costs and losses. It means loss of opportunity to develop the truth. A good claim agent or adjuster gets on the job immediately, leaves nothing to chance, and makes no assumptions. He gets the facts immediately, before people's memories fade and clues are washed out. If the employer's interest is to be protected and justice is to be done to all parties involved, we must have the truth, and the unvarnished truth. Delay on the part of the adjuster often prevents him from getting the unvarnished truth. Facts are colored intentionally or unintentionally by prejudice or sympathy.

The claim agent and adjuster have the responsibility to make a complete and thorough investigation; present their report in a factual manner which can be readily read and understood; and prepare the file so that it is what it should be—a body of facts organized as an intelligible whole. Conjecture, assumptions, generalities, and guesses should be eliminated. Truth is fundamental and that is what your file should contain—the truth, the whole truth, and nothing but the truth —assembled in a factual statement.

Your investigation file is your handiwork. It is your appearance, your presentation, your step to promotion, your springboard to success. It is your chance to demonstrate your ability to do a staff job—a thorough and comprehensive report on all germane matters covering the accident. Remember that the man who reads that file may never have met you. He predicates his opinion of you on that file. Make it the kind of a job which can be held up by your employer as an example of a real investigation and report.

The claim agent or adjuster is an important cog in the administration of justice. He is, if he does his job well, the champion of truth. Upon him rests the obligation to protect not only his own reputation but that of his employer and the industry of which he is a part.

The claim agent or adjuster must make the initial determination of liability or nonliability. He must decide whether a further investigation is warranted. If in doubt, in serious cases, the file should be sent to the trial attorney so that he can determine what he will need by way of

further investigation. Action should not be deferred until the time of trial because it will then be too late to develop evidence which might defeat the claim.

Finally, the defense attorney often determines what witnesses to use from a reading of the file. It is always helpful to have the adjuster's impression of the value of each potential witness.

In a word, the successful claims man must face the rising litigation problems with real thought and inventiveness. He must advance with the changing times, and keep abreast of advances in science, and social and economic changes. He must apply creative thinking to his job. If he does so, he will be a real asset to his company and get real pleasure out of his job. And that is, after all, the true test of success.

In conclusion, I would like to say this: You claim men are the first line of defense against the plaintiffs' lawyers who have now lifted the lid on expenses, with the sky as the limit. Many of them have their own investigators. These men—your opponents—are usually highly skilled and well-trained. Most of them gained their experience with the insurance companies and then abandoned them because of a better financial offer from the other side.

As a matter of fact, many of the outstanding plaintiffs' attorneys themselves also started as defense attorneys for insurance carriers and then abandoned them because they found it unprofitable to continue with the defense of insurance cases.

Both these trends are likely to continue if the cost-consciousness of the insurers continues.

The most effective demonstrative evidence techniques in use today are employed by plaintiff's counsel; they are of course more readily adaptable to the plaintiff's case, but they are in some instances equally adaptable to the defendant's case. However, the insurers are often reluctant to spend the money, while plaintiffs are looking for the opportunity to do so. The more elaborate the plaintiff's presentation becomes, the larger the verdict or potential verdict.

Let us ask ourselves, isn't this a classic case of fighting fire with fire? If plaintiffs are going all out to build up their cases without regard for expenses, how can we expect to combat these build-ups except by equally vigorous efforts. Isn't our only defense better investigation and better preparation all along the line? Of course we cannot be successful all the time, but the cases in which we are successful will more than defray the costs involved in the whole program. Moreover, by putting up a fight when a fight is justified we can also realize some deterrent effect. Today, our apathy is actually encouraging suit in practically every case regardless or liability or actual injury.

We have to face these two basic facts:

(1) Better preparation is essential; and

(2) An arbitrary limit on costs makes that preparation impossible.

The choice, gentlemen, is for the insurers to make. And no one can save them from themselves—not even a Philadelphia lawyer.

# Claims Under Reinsurance Policies and Treaties

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WITH the continual increase in the ad damnum and the number and size of awards, it has become necessary to give more attention to the notice requirements of claims under reinsurance policies and treaties and some of the problems that arise in connection with reinsurance claims.

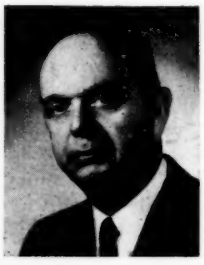
There are not too many reported cases dealing with litigation between parties to reinsurance contracts and treaties. The scarcity of this type of litigation is understandable. In the first place, these contracts are between two insurance companies; hence, the parties are experts in their field. They are better able to understand the terminology used and the intent of the contract. In *Fidelity & Deposit Co. v. Pink,* 302 U.S. 224, 229, the court said:

> "The contract though usually drawn by the reinsurer is an insurance instrument drawn between experts on both sides—so that both parties stand on an equal footing."

There is a great deal of good faith exercised and I think a genuine understanding of the moral obligations involved. The terminology that is found in most of the arbitration clauses is a good example of the attitude of the parties to these contracts. After the usual provisions for the selection of arbitrators, in the event of a dispute or difference of opinion, language comparable to the following is usually inserted:

> "The arbitrators shall consider this contract as an honorable engagement rather than merely as a legal obligation and they are relieved of all judicial formalities and may abstain from the strict rules of law.**"

The dearth of ligitation in this field is partially explained by the fact that these reinsurance contracts and treaties are actually comparatively simple. They do not contain the "fine print" provisions that we all are accustomed to in dealing with in straight casualty insurances which, of course, have been the source of considerable amount of litigation over the years.



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To begin with, reinsurance basically may be divided into two classifications—facultative and treaty. Under facultative reinsurance, an insurer offers to cede one individual risk that it has insured to another company called the reinsurance company. Treaty insurance involves a practice between insurers whereby a contract is entered into providing that both the reinsured and the reinsurer are automatically bound in advance as respects all risks that fall within the terms of this agreement. Someone once defined facultative business as "a la carte" and treaty business as "table d'hote".

While facultative reinsurance predates treaty reinsurance, the latter form now occupies a primary place in the field. Obviously, treaty reinsurance has several advantages. It avoids the necessity of securing an agreement on each individual risk. It avoids delay—and avoids the possibility of a loss accruing before the reinsurance is procured. If reinsurance is necessary before writing, it avoids the possibility of losing the business while seeking a reinsurer.

In the usual form of treating insurance —as long as the risk falls within the type of business specified in the treaty, the reinsurer is under a duty to accept it. In fact, under the terms of the treaty he is automatically bound when certain classes of risks are written by the reinsured.

A word above the various types of reinsurance—

*Quota share reinsurance* is the name applied to a contract under which the re-

insurer reinsures a certain percentage of each original risk. That is, it takes a share from the ground up.

In *surplus reinsurance* or *excess of loss reinsurance* the reinsured retains a fixed amount of the original risk and the reinsurer takes an agreed amount in excess of that retention.

*Quota surplus reinsurance* is, of course, a combination of both—i.e., the reinsurer takes a percentage of the original risk in excess of a certain amount retained by the reinsured.

These definitions cover the principal types of contracts, but it must be remembered that these contracts are "tailor-made" and there are many variations which are largely a matter of negotiation, depending, to some extent at least, upon the volume of business being ceded under the contract or, in cases of notice requirements, the extent and scope of the claim-handling facilities maintained by the reinsured. Obviously, the contract must be carefully studied and understood before a claim reporting procedure can be set up.

The reinsurance treaty usually provides a currency period, or it may be continuous, subject to termination upon notice. In some instances, the contract will provide that all policies written during this period are covered to the termination date of such policies so written. In other treaties the coverage is provided in respect of all losses occuring during the currency of the treaty, without regard to the effective date of the primary policies or their termination dates.

The amount of the retention and the limits of exposure are, of course, specified. In a *surplus* treaty there will be a specification of the amount of the retention by the reinsured and the amount in excess ceded to the reinsurer and a top limit on the reinsurer's exposure will be specified. In the *quota-share* treaties the percentage of the entire risk retained and ceded will be specified and in *quota-share* surplus treaties there will be a specification of the retention by the reinsured and then the percentage participation in the surplus over that retention. There are the usual definitions of the ultimate net loss, what constitutes expenses, and the participation in salvage and recoveries, etc.

There are a variety of requirements for claim-reporting, varying from a bordereau report to specific detailed reports respecting claims that might involve the reinsurer. Oftentimes the treaties will exclude certain types of risks. These specific exclusions are again a matter of negotiation. The ceding or reinsured company will exclude these classes, because its writings in this type of business are within its capacity.

Oftentimes, too, certain so-called "target risks" are excluded. This exclusion is inserted at the request of the reinsurer, which probably has some direct insurance on these risks and does not want any more coverage through reinsurance treaties. Incidentally, for this same reason, you will oftentimes find the reinsurer inserting the so-called atomic energy exclusion clause, simply because the reinsurer is probably a member of a pool writing that type of coverage and, again, wants no more under a reinsurance treaty.

It should be remembered that a contract of reinsurance is one of indemnity against loss between the reinsured and reinsurer. The original assured is not a party to it and has no rights under these policies. A few years ago a reinsured company endorsed on the margin of its fire policies, "this policy is reinsured at Lloyd's". When a claim was refused, suit was filed and, of course, Lloyd's were named as a defendant. A motion to dismiss was successful upon the ground that there was no privity of contract. That principal was recently reiterated in *Gill v. Peerless Casualty Co.*, 18 Ill. App. 2d 338, where the court said, at page 344:

> "By none of the provisions of the agreement did appellee obligate itself to pay any loss sustained by a policyholder of the Blackhawk Company to such policyholder. Its agreement was to pay the Blackhawk Company but only after the Blackhawk Company had paid a loss on a claim in excess of $5,000. The express language of this agreement makes it an excess reinsurance contract and as such its provisions are not enforcible by appellant."

As respects the reporting of claims, there is a divergency of ideas as to rights and obligations of the respective parties. On the whole, there is, I think, a healthy attitude of cooperation and the problems are few—but reinsurers have on rare occasions encountered some unyielding opposition to inquiries on the status of claims. Some companies take the position that the rein-

surer's only right is to pay as soon as the reinsured submits its periodical statement for the reinsurer's proportionate share. Some are stringently opposed to any independent participation because they do not want it known by the original assured that they have reinsured the risk.

On the other hand, some reinsureds quite frequently go beyond the requirements of the policy to see to it that the reinsurer is given all available information on the pending claims that might go beyond its retention, and oftentimes they will submit detailed investigation reports with a request that the reinsurer express its ideas as to value. Such was the case just recently under a reinsurance treaty which simply provided:

> "In the event of a claim occurring which may cause a claim under this contract estimated to equal or exceed an amount of $2500, notice shall be given by the reinsured to the reinsurers as soon as practicable."

In this instance, the reinsured was dealing with a potential claim of $25,000 that could be settled for approximately $15,000. The reinsured sent copies of all of its investigation reports, together with its analysis of the file, and held off the claimant until such time as the reinsurer could review the facts and make its own decision respecting payment. That kind of a working arrangement does, of course, avoid many problems and I am sure that, as a result of that kind of cooperation, the company involved will negotiate future treaties with the minimum amount of detailed reporting requirements.

Not all of the difficulties are the result of deliberate policies or attitudes. In many of the larger companies, the branch offices are not informed of the existence of reinsurance. They simply report the claims and the current developments to the home office, and it is there at the home office that the required reports to the reinsurers are compiled. You can readily understand that, under such an arrangement, current developments that can affect the claim evaluation do not reach the reinsurer until after the branch office gets off a report to the home office and until the home office forwards it on to the reinsurer, either on the next periodical bordereau report due or in a special report if required under the terms of the treaty.

I do not know whether any other system is practicable, but if a procedure could be set up where copies of reports on claims in excess of a certain dollar amount could be forwarded to the reinsurer by the branch office, a great deal of unpleasant surprises could be eliminated.

Both the reinsured and the reinsurer have stakes in the claims. The reinsurer must establish its own reserve. Not infrequently under some treaties, it has a right to participation in the actual handling of the claim—usually at its own expense. Clearly then, it is entitled to a reasonably prompt notice of the claim and developments.

A case that demonstrates the very substantial stake a reinsurer has in the handling of claims is *Inland Mutual Insurance Co. v. Peerless Insurance Co.*, 152 F. Supp. 506, affirmed 251 F. 2d 696. In this case Inland paid $27,500 in settlement of certain litigation and incurred expenses totaling $11,560.99. Under its reinsurance treaty, it sought reimbursement for two-thirds or $26,040.66 from Peerless. Inland had issued an automobile policy to Lota Yeatts with limits of $15,000 any one person. Inland retained $5,000 and ceded to Peerless the excess. Inland received notice of an accident on April 23, 1951, and set aside $1500 as a reserve. A week later this reserve was increased to $3,500. On November 21, 1951, the reserve was again stepped up to $7500 and Peerless was sent a "preliminary loss advice". By the time suit was filed for $125,000 six letters had passed between Inland and Peerless. The Peerless claim supervisor went to the office of Inland and examined its file. Medical reports were furnished Peerless. There was some disagreement as to the value of the case, but Peerless did not participate in the handling as it had a right to do. The claimant demanded $60,000 in settlement and both Inland and Peerless considered this too high. On the second day of trial, a demand of $17,500 was made. The assured (Yeatts) agreed to put up $2500 and demanded that Inland pay $15,000. The trial attorney for Inland recommended payment but, after Inland and Peerless conferred, they offered $7500. The jury returned a verdict for $75,000. Inland paid Yeatts, the assured, $15,000 and was reimbursed $10,000 by Peerless. Yeatts sued Inland, which suit Inland finally settled for $27,500. Inland then sued Peerless seeking two-thirds of the expenses.

The provisions of the treaty respecting notice and the right of the reinsured to participate were, in part, as follows:

*"Article III*

"Liability of Reinsurer:

"The actual payment by the company of any loss shall be a condition precedent to any recovery under this agreement, and subject to such condition, the liability of the reinsurer shall follow that of the company in every case and shall be subject in all respects to all the general and special stipulations, clauses, waivers and modifications of the company's policy, binder or other undertaking, and any endorsements thereon.

"No error or omission in reporting any risk reinsured or marked to be reinsured shall invalidate the liability of the reinsurer; but the reporting of reinsurance not authorized by this agreement or by special acceptance hereunder shall not bind the reinsurer except for the return of premiums paid therefor."

*"Article IV*

"Claims:

"The company will advise the reinsurer promptly of all claims and any subsequent developments pertaining thereto, which may in the company's opinion develop into losses involving reinsurance hereunder.***

"When so requested, the company will afford the reinsurer an opportunity to be associated with the company, at the expense of the reinsurer, in the defense or control of any claim or suit or proceeding involving this insurance.***

"All court costs and expenses***shall be apportioned in proportion to the respective interests as finally determined. ***"

The court, in allowing Inland to recover, pointed out:

(1) Inland kept Peerless fully and adequately informed;

(2) If Peerless tried to get Inland to settle because the case was dangerous, then it must have known all about it and will not be heard to say he was not sufficiently informed;

(3) The handling of the case was for the mutual advantage of both parties.

On page 512 the court said:

"Peerless takes the position that its liability under the reinsurance agreement was limited to the dollar coverage of the policy issued the insured. In the Yeatts policy, the limit of liability for personal injury was $15,000, of which Inland retained $5,000; Peerless claims that when it paid $10,000 on the Yeatts policy, it completed all its obligations under the reinsurance agreement (except paying two-thirds of the expenses of the suit, which Peerless admits it owes). Inland however, points to Article III of the reinsurance contract quoted above, which it states that the liability of Peerless follows that of Inland in every case and shall include all undertakings of Inland with respect to every policy issued and covered by the reinsurance agreement.***"

On page 513 the court said:

"Applying the unambiguous language of Article III, above, to Inland's undertakings under the Yeatts policy, the conclusion is inescapable that Peerless's liability followed Inland's, including liability to defend, investigate, negotiate, and settle any claim or suit against the insured. Defendant's contention that all it was required to do was pay $10,000 on the Yeatts loss is untenable.*** Inland was required to stand ready to pay up to $5,000 to Yeatts for personal injury liability; Peerless was required to stand ready to pay an additional sum, up to $10,000; the *two* companies were required to defend, and allowed to investigate, negotiate and settle any claim or suit against Yeatts, and share the costs of such action (except for salaries of their own officials and employees) according to the interests of the two companies as finally determined when a claim was paid."

Certainly, this case demonstrates the vital interest of the reinsurer. It certainly has the right, in view of this ruling, to carefully examine a reinsured's file—and it seems to me also, the case illustrates a sound reason why the reinsured should keep the reinsurer fully advised. The reasoning of the opinion is largely based not only upon the participation of Peerless in the handling of the claim, but upon its right to act if it elected to so after notification.

Where there is a specific notice requirement in a policy it must be complied with or a reinsurer might be relieved of his liability. In *Keehn v. Excess Ins. Co. of America,* 129 F.2d 503, the defendant, Excess Ins. Co., issued a reinsurance contract to the Central Mutual Ins. Co., whereby Excess reinsured Central on automobile public liability risks above certain amounts assumed by Central. A suit was instituted against one of Central's assureds on February 26, 1935. The suit was unsuccessfully defended by Central. Upon refusal to pay the judgment, a garnishment was instituted and a garnishee judgment against Central was entered. Upon appeal the judgment was affirmed and paid by the surety on the appeal bond, using funds deposited by Central as security. Roy Keehn, as receiver of Central, then sued the reinsurer for its proportionate share. No notice was given Excess (the reinsurer) until shortly before the appellate court had affirmed the garnishment judgment.

The reinsurance policy had the following provisions respecting notice:

> " 'Section IX. The company shall notify the reinsurer immediately after it has had notice of any accident in which this reinsurance is or may probably be involved. Such notice shall be given to the reinsurer on preliminary loss advice on forms as per copy attached, and when final settlement is made the reinsurer shall advise on final loss advice on forms as per copy attached.
>
> " 'The reinsurer shall have the right and opportunity to associate with the company in the defense and control of any claim or suit or proceeding relative to an accident where the claim or suit involves this reinsurance.' "

On page 505 the court said:

> "The court also found that the failure to give notice deprived defendant of the right and opportunity to associate with Central Mutual in defense and control of the Snow suit, and that the rights of defendant were prejudiced thereby. Plaintiff argues there is no justification for this finding, as there was no proof that the results would have been different if the defendant had been permitted so to do.***The right was provided by the terms of the contract and we are of the view that the deprivation of such right would constitute prejudice without any actual proof that the results of the litigation would have been different."

There are, of course, a variety of specific requirements respecting notice set forth in the different types of policies. In a straight facultative policy for 50% of the underlying risk, a frequent provision is:

> "The reinsured shall notify the reinsurers of any claim or claims advised under the original policy and shall furnish the reinsurers hereon with all available information***. Inadvertent omission or oversight*** shall in no way effect the liability of the reinsurers***."

This requirement is, of course, specific. Furthermore, it involves only one assured and the reinsurer is on for 50% (quota share) of the entire risk. In such a case he has a vital interest from the ground up.

In an excess reinsurance contract where the reinsured retained the first $5,000 the treaty provided:

> "The company (reinsured) will advise the reinsurer promptly of all claims and any subsequent developments, which may result in a claim upon the reinsurers hereunder***."

It goes on to provide that the "reinsurer will be given the opportunity to be associated with the reinsured, at the expense of the reinsurers, in the defense or control of any claim or suit, etc."

The provisions respecting notice in a quota-share reinsurance treaty recently examined simply provided:

> "The company shall also forward to the reinsurer monthly bordereau of claims paid and losses outstanding, showing the total amount of the claims paid or the reserve set up therefore, together with expenses and the proportion applying to this agreement of reinsurance."

The treaty also provides:

> "The reinsurers or their representatives shall at all times have the right to inspect the books and all other documents relating to this agreement."

This, in a sense, more or less places the burden on the reinsurer. If it sees some substantial reserves on the bordereau report, I presume it could request the claim file for examination.

From the foregoing examples, it is perfectly apparent that there are quite a variety of notice requirements under different types of policies and, for that matter, there are differences in the same types of reinsurance contracts. Obviously, there is an element of discretion involved. Probably the form of report specified most frequently is the bordereau report. At least that is the usual provision in quota share treaties. These treaties generally provide for several forms of monthly bordereau reports—one will include all notices of losses with reserves; the second will include all paid losses (which incidentally is also treated as a demand for reimbursement); and the third will include all reports on salvage recoveries. From these three reports, of course, the reinsurer, by removing from "notice of loss bordereau" all those claims that appear on the "paid losses" and adding the salvage recoveries, each month, can compute its loss experience. There are other bordereau reports required respecting premiums, commissions, etc.

As mentioned before, these conditions are the by-products of negotiation. There is no set requirement in each type of contract or treaty.

It is interesting to speculate as to what might have been the outcome in the case of *Inland Mutual v. Peerless Casualty*. If, instead of the specific requirement to advise the reinsurer promptly of all claims and subsequent developments and afford the reinsurer an opportunity to be associated with the company, there was one of the foregoing minimal requirements of a simple bordereau report of losses outstanding, with the right on the part of Peerless to inspect the files of Inland. Under such an arrangement, there would, of course, have been a considerable lapse of time between the bordereau reports showing a reserve increase. You will also remember that the largest reserve established by Inland was $7500, which, if it appeared in a bordereau report, would not have been particularly alarming, in view of the fact that Inland's retention was $5,000. The probabilities are that, under such circumstances, Peerless would have taken no action at all and, strictly speaking, Inland would have complied with the bordereau notice requirements.

Under such circumstances, the court could not have relied as much as it did upon the activity of Peerless Casualty in evaluating the claim and participating in the negotiations.

I can readily see where there might have been an entirely different result if there were nothing more than a compliance with the minimum requirements of the notice provision. In discussing this point with a reinsurance underwriter the other day, he took the position that in spite of the minimal bordereau report requirements there is a moral obligation to go beyond the terms in such instances and that such an obligation is recognized and followed by both parties to reinsurance contracts and treaties.

These two cases—the *Inland* case and the *Excess* case—demonstrate, it seems to me, that the reinsured has everything to gain and nothing to lose by going beyond the minimum requirements of the policy in giving notice of at least the claims with serious possibilities. If the reinsurer elects to go along in refusing to settle the claim within the limits of the basic policy, then, under the *Inland* case, it can be held liable for its share beyond the policy limits in the event of a "bad faith" claim. If, on the other hand, the reinsured company simply gives the minimum amount of notice required and does not keep the reinsurer advised of developments and does not obtain its acquiescence in the future handling of the claim, then, in the event of a charge of bad faith or negligence in handling, there might be considerable doubt as to whether a court would impose a share of such liability upon the reinsurer as was done in the *Inland* case. Of course, if no notice at all is given, then it is quite likely that the reinsurer may not be held liable at all.

In a somewhat prophetic paper written by David L. Tressler, a member of the Executive Committee of the International Association of Insurance Counsel, prior to the decision in the *Inland* case, he made these comments on the potential liabilities of the reinsurer—

> "Bearing in mind that the reinsurer shall follow the fortunes of the reinsured, the question frequently arises concerning the position the reinsurer will take in those instances when the primary carrier is held liable for an excess verdict which exceeds the reinsured's retention.
> ***
>
> "Assuming that the policy limits are sufficient to exceed the reinsured's reten-

tion and the matter has been adequately reported to the reinsurer and it has agreed with the reinsured to reject the claimant's offer to settle for an amount within the policy limits (and perhaps even within the reinsured's retention), then I believe that the reinsurer by reason of its acquiescence in the defense strategy, has become a party to the reinsured's negligence or bad faith, or both in the defense of the claim even though not actively engaged in the defense. It stood to profit by successful defense, and for the same reason should stand to lose by the adverse outcome, and should thereby indemnify the reinsured accordingly, or be estopped from denying liability under its contract of indemnification.

"Next, if through hindsight it honestly would have concurred in the reinsured's position of rejecting settlement, had the case been reported to it prior to the excess verdict assessed by reason of the *negligence* (and I stress the word negligence), I believe it would also follow the fortunes of the reinsured and be liable.

"Next, under a third set of circumstances involving the failure to report to the reinsurer on a loss involving policy limits in excess of the reinsured's retention where the excess verdict is based on the conduct of the reinsured that is construed as *bad faith* rather than mere negligence, the reinsurer would, in my opinion, not by any set of standards be held liable to indemnify the reinsured, for it could not under any fiction be made a party to bad faith or misconduct, or estopped from denying liability.

"Next, even in an instance comparable to the preceding hypothetical case where the loss had been reported to the reinsurer with its potentialities, but the proposition of settlement was never presented to the reinsurer, and the reinsured then became guilty of bad faith or misconduct in rejecting the settlement proposition, I believe that the reinsured should be solely responsible for its acts, and liable in damages in the form of the excess verdict without right to indemnification from the reinsurer.***"

I know of no cases involving suits charging insufficient notice of reinsurance policies which simply require a monthly bordereau report of notice of losses and claims paid. Perhaps a "no more no less" compliance might be held sufficient, but I believe it would be good practice to do more in the case of serious claims. After all, these bordereau reports sometimes consist of reams of sheets containing many columns of figures. Items can be and are omitted. Conditions do change between reports.

You are familiar with the case of *American Surety & Casualty Co. v. American Bus Lines*, 190 F. 2d 234, where the court held the primary carrier liable to the excess carrier on a charge of bad faith in handling the claim under the primary policy which resulted in a loss to the excess carrier. Certainly, if such an obligation exists where there is no privity of contract between the parties, there is even a greater obligation in a case of a reinsurance contract where privity does exist. The reinsurer has a vital stake "and right to inspect the books and all other documents relating to this agreement" and, in some instances, a right to participate. Good faith requires notification on serious problems that might be hidden away in a voluminous bordereau report.

It must be remembered that the reinsurer's only source of information is the reinsured. Litigated matters can go on for many years without any knowledge on the part of the reinsurer, if no notice or inadequate notice is given. Neither the injured claimant, nor the original assured, has any right to proceed against, nor an obligation, to notify the reinsurer. He has no knowledge of the existence of the contract.

I well realize that this business of reporting is considered by most of us to be a nuisance. I suppose one of the most neglected duties of a lawyer is the job of advising clients of the status of matters, and I presume the same problem exists in the insurance industry. Nevertheless, I am equally sure that there is no better trouble preventative than an established line of communication among all interested parties. Of course, it can be overdone, and I am sure that the last thing that a reinsurer wants is to receive a basket full of so-called precautionary notices with each mail delivery.

If you are concerned with the possibility of a reinsurer exercising its option to participate in the handling of a claim, let me just say that in about ninety-nine and nine-tenths per cent of the cases if a reinsurer is adequately informed, it will elect to follow the fortunes of the reinsured.

# An Introduction To Admiralty and Maritime Law*

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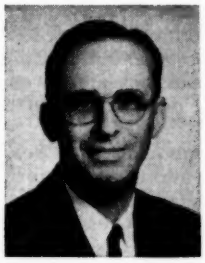
MARITIME LEGAL PROBLEMS at an international port, or at any port, cannot be solved by admiralty law alone. A modern legal Solomon of pure admiralty jurisdiction would be a poor choice as counsel for a ship-owning newcomer to the Port of Chicago. Admiralty law is ancient,[1] and it is international,[2] but it must direct its course between the thousand poorly charted reefs of federal statutes, state statutes, city ordinances, departmental regulations, treaties, international conventions, court decisions, and administrative rulings. A channel through all this to a chosen destination can frequently be found by those having sufficient determination. Vessels and what they carry, how safely they carry, what they charge for the service, what they buy, their personnel, and the behavior of the vessel and its crew in ports of call are all subject matter of maritime law, although much of this would not be within the jurisdiction of a United States district court sitting in admiralty.[3]



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## A LEGAL KALEIDOSCOPE

Admiralty law in the United States, rather restricted in the beginning on account of the influence of the British common law, has grown into a fairly comprehensive system, having been broadened by international conventions, federal statutes, court decisions, and even state statutes. It deals with matters of contract that have a maritime flavor, with torts on navigable waters, rights of vessel personnel and of passengers, collision, salvage, general average, marine insurance, and numerous other subjects. Changes in the attitude of Congress and of the Supreme Court have sometimes restricted the uniformity and harmony of maritime law and sometimes have broadened it as adopted and applied in this country. The rights of seamen and the rights of marine workers who are not seamen during the past forty years have gone through kaleidoscopic changes with each new example of judicial legislating, so that no one can predict which pattern will turn up next. These changes have been primarily in the national and local aspects of the subject rather than the international. Even as to the international aspects of general maritime law there are many differences in substance and in application by American courts as compared to foreign courts, and this difference is not limited to statutory changes in the United States. A considerable part of the business of a vessel is subject to surveillance by customs officials, Coast Guard officers, and other officers of the federal government, seldom reaching the desk of a lawyer, maritime or otherwise. The public hears of the United States Coast Guard because its operations are often spectacular; it renders assistance to vessels in distress and and these activities appear in the public press. Its duties really extend far beyond

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[1]Gilmore & Black, The Law of Admiralty 2-11 & nn.3-36 (1957).

[2]*Farrell v. United States*, 336 U.S. 511, 69 Sup. Ct. 707 (1949).

[3]1 Benedict, The Law of American Admiralty (6th ed. 1940) (particularly paras. 10 and 10a).

that service. It examines and licenses masters, mates, engineer officers, and other personnel of our merchant vessels. It inspects vessels for safety purposes. It maintains buoys, lighthouses, radio direction finders, beacons, and other aids to navigation, and it enforces regulations governing the anchoring of vessels in our ports. The navagation rules or rules of the road, such as passing signals, speed, right of way, lights, and fog signals, are contained in federal statutes,[4] which are supplemented by Coast Guard regulations. Violations are investigated and penalties are determined by the Coast Guard.[5]

The Bureau of Customs has a wide range of marine activities in addition to collecting duties. It attends to enrollment or registry of vessels,[6] it measures vessels being built to determine tonnage, it issues licenses to vessels, it attends to entry and clearance at United States ports, records bills of sale and ship mortgages, and handles many fines, penalties, and forfeitures for violation of shipping laws. It is natural that much of this Customs and Coast Guard business with water carriers is handled with those agencies by shipowners and charterers, or their agents rather than by lawyers.

### *Rates and Routes*

Rates and routes of water carriers for carrying of cargoes in the domestic trade are subject to part III of the Interstate Commerce Law, enacted in 1940.[7] This regulatory legislation is not maritime law, but its effect is wide enough to touch the maritime lawyer at various points. Rates in foreign trade are not fixed by any commission nor controlled by any government body except to the extent that discrimination is outlawed and conference agreements are subject to approval of the Federal Maritime Board, which has on file more than one hundred such agreements. Congress has enacted many laws designed to foster a strong merchant marine for use in case of war or national emergency. One of the principal forms of aid has been payment of construction subsidies and operating differential subsidies for the purpose of placing American flag operation on an equality with the less costly service of foreign lines. The United States does not stand alone in the matter of subsidies, as almost every maritime nation of the world at one time or another has subsidized its foreign trade merchant shipping.[8]

### *Federal Power To Legislate*

The United States Constitution, article III, section 2, provides that the judicial power of the United States shall extend to matters of admiralty and maritime jurisdiction. This has been construed, along with the commerce clause, to give Congress power by legislation[9] to modify and supplement the general maritime law[10] which our courts originally recognized.[11] Congress has made use of that power during the entire history of the country, sometimes with consummate skill and at other times in patchwork fashion. At the present time some of our federal statutes on shipping are confused and difficult to understand, are in need of codification, but are difficult to streamline without endangering court interpretations and established practices in the industry. The Supreme Court has referred to the marine inspection laws as a "maze of regulation"[12] and to our shipping laws generally as "a patchwork of separate enactments, some tracing far back in our history and many designed for particular emergencies."[13]

[4] 28 Stat. 645 (1895), 33 U.S.C.A. § 241 (1957).

[5] Rev. Stat. § 4450 (1875), as amended, 46 U.S.C.A. § 239 (1958).

[6] Rev. Stat. § 4132 (1875), 46 U.S.C.A. § 11-82 (1958).

[7] 54 Stat. 929 (1940), 49 U.S.C.A. §§ 901-23 (1951).

[8] See 39 Stat. 733 (1916), 46 U.S.C.A. § 814 (1958) (Shipping Act of 1916). *Campagnie Gen. Transatlantique v. American Tobacco Co.*, 31 F.2d 663 (2d Cir. 1929). Brooking Institution, The United States Shipping Board c. 1 (1931); Zeis, American Shipping Policy (1938); Saugstad, Shipping & Shipbuilding subsidies (1932); Spears, The Story of the American Merchant Marine c. XVI (1910); Editors of Fortune, Our Ships (1938).

[9] *Detroit Trust Co. v. The Thomas Barlum*, 293 U.S. 21, 55 Sup. Ct. 31 (1934): "Congress thus has paramount power to determine the maritime law which shall prevail throughout the country," *Panama Ry. v. Johnson*, 264 U.S. 375, 44 Sup. Ct. 391 (1924).

[10] *American Ins. Co. v. Canter*, 26 U.S. (1 Pet.) 511, 545-46 (1828); *Insurance Co. v. Dunham*, 78 U.S. (11 Wall.) 1 (1871); *De Lovio v. Boit*, 7 Fed. Cas. 418 (No. 3776) (C.C.D. Mass. 1815). These cases discuss what the constitutional grant of jurisdiction includes as general maritime law.

[11] *The Western Maid*, 257 U.S. 419, 42 Sup. Ct. 159 (1922). Here Mr. Justice Holmes said: "There is no mystic over-law to which even the United States must bow. When a case is said to be governed by foreign law or by general maritime law that is only a short way of saying that for this purpose the sovereign power takes up a rule suggested from without and makes it part of its own rules."

[12] *Kelly v. Washington*, 302 U.S. 1, 58 Sup. Ct. 87 (1937).

[13] *Lauritzen v. Larsen*, 345 U.S. 571, 73 Sup. Ct. 921 (1953).

*Domestic Commerce; Pilotage*

The first Congress of the United States enacted two shipping laws which have been of importance ever since. First, it undertook to exclude from American flag enrollment all vessels except those built in the United States and owned by its citizens. In 1817 Congress expressly reserved the coastwise trade for American vessels, a law which, as amended, continues to exclude all foreign vessels from trade between any two United States ports.[14] Foreign trade is not restricted in this fashion.

The first Congress also dealt with pilotage by providing that pilots in the bays, inlets, rivers, harbors, and ports of the United States shall continue to be regulated in conformity with the existing laws of the states, or which the states might enact.[15] As of 1789 several of the states had well established pilotage systems and there was no federal system in existence. Licensing of pilots in our domestic commerce under federal laws has been extended from one class of operation to another over the years by congressional enactment so that today most of the American vessels enrolled in the coastwise trade must carry federally-licensed pilots and are exempted from state pilotage laws. However, American vessels that are registered for foreign trade, and all foreign flag vessels, must comply with state pilotage laws wherever they have been enacted.

We permit masters and pilots duly licensed by foreign countries to navigate into our ports, subject to compliance with the state pilotage laws, if any. Thus, foreign vessels may come into the Great Lakes without using local pilots, although most of the foreign vessels do employ Canadian pilots who have had experience navigating the Great Lakes so that they shall be available during the transit of any dangerous or restricted channels. Thus far none of the states bordering the Great Lakes has enacted local pilotage laws and it is probable that they will not do so if federal regulation, now proposed in a bill sponsored by the Coast Guard, becomes law. As a class, the officers of foreign vessels are very able but some of them are said to be insufficiently conversant with the Pilot Rules for the Great Lakes, local rules in ports, and some of our picturesque seagoing slang used over the radio telephone. These are some of the reasons why the Coast Guard believes that the carrying of a pilot licensed under either United States law or Canadian law is essential to insure greater safety in vessel operation. The problem of securing such temporary pilots who are qualified and the added expense would create problems of severe proportions. However, unless federal licensing provisions can be agreed upon and enacted, it seems possible that some of the Great Lakes states will begin to enact pilotage laws. This could result in a lack of uniformity, confusion, and undue expense for vessels engaged in foreign trade.

VESSEL AND CARGO

*Classification Societies*

It is important for shippers and charterers to know the nature, construction, and seaworthiness of vessels which carry their cargoes. For this purpose and in order to help shipowners keep their vessels in proper order, Lloyds Register of Shipping and other international classification societies have grown up. The American Bureau of Shipping is a classification society whose principal function is to establish and maintain proper standards applicable to construction and maintenance of merchant vessels for the protection of shipowners, underwriters, shippers, and others. A vessel's "class" or rating is an expert opinion of her build, condition, and upkeep, and an indication of her seaworthiness for any particular trade. Surveyors of this bureau will supervise construction, make periodic surveys, damage surveys, and issue certificates of seaworthiness for specific cargoes, as, for example, grain. This society is a New York corporation not-for-profit organized in 1862, having on its executive committee some representatives of federal government departments. It has semiofficial status as an agency of the government[16] and, pursuant to appointment by the Commandant of the Coast Guard, determines whether load lines are correctly placed.[17] The class of vessels is often stated in charters and is of commercial importance in negotiations for the hiring of vessels. There are other similar societies in foreign countries, such as Bu-

[14]See Rev. Stat. § 4132 (1875), as amended 46, U.S.C.A. § 11 (1958); Rev. Stat. § 4311 (1875), 46 U.S.C.A. §§ 251-336 (1958) (registration of vessels; enrollment in domestic commerce); 41 Stat. 998 (1920), 46 U.S.C.A. § 883 (1958).

[15]Rev. Stat. § 4235 (1875), 46 U.S.C.A. § 211 (1958). *Cooley v. Board of Wardens*, 53 U.S. (12 How.) 299 (1851).

[16]41 Stat. 998 (1920), 46 U.S.C.A. § 881 (1958).

[17]45 Stat. 1493 (1929), 46 U.S.C.A. § 85b (1958); 46 C.F.R. §§ 43.01-40 (rev. 1952) (appointment perfected).

reau Veritas,, whose surveys are generally accepted just as are those of the American Bureau of Shipping. The evolution of vessels for cargo carrying, general and specialized, has had an amazing history[18] The earlier steamship inventions, combination of sail and steam, and efforts to increase speed[19] and size[20] of vessels comprise a specialized subject by itself. The classification societies have done much for the safety, improvement, and standardization of vessels, whether liners or tramps, deluxe passenger craft or rust buckets.

### *Tramp Shipping and Liner Service*

Tramp shipping implies the absence of regularity or even of continuity in serving any particular part of the world. The operation of tramps into the mid-continent of North America depends upon trade being rather brisk here or worse somewhere else. The so-called liner service, which has been offered to the Great Lakes in increasing volume since 1935, involves the carrying of general cargoes for a number of separate shippers on fairly regular schedules, and is considered to be a common carrier service, but without any statutory requirement of a certificate of convenience and necessity. Neither the common law nor the admiralty law impose any obligation upon a water carrier to continue a common carrier service in the absence of statute, and it may cease to operate if it sees fit.[21] Historically, the common carrier by water was held liable in United States courts as an insurer under the general admiralty law and under the common law and could not be exempted by contract for any losses resulting from negligence of the carrier's employees.[22] The British courts in the nineteenth century and early part of the twentieth century upheld bill of lading exemptions from liability even if the loss was due to negligence. Near the end of the last century cargo interests were dominant in the United States, but the interests of vessel owners prevailed in England to such an extent that there was a considerable difference in the laws of these two countries. Our merchant marine was then at a very low ebb. However, in 1893, after many conferences, domestic and international, Congress adopted the Harter Act[23] which exempted a carrier from liability for negligence in the navigation or management of the vessel, provided the vessel was seaworthy and properly manned, equipped, and supplied; but it did not permit exemption for negligence in the care and custody of cargo. This statute applied to foreign trade in both directions, could be adopted by reference into bills of lading in our coastwise trade, and could be incorporated into contracts of private carriage.[24]

### *Hague Rules and the American Carriage of Goods by Sea Act*

The general principles of the American Harter Act were soon adopted by statutes in Canada, Australia, and New Zealand; they were urged upon the British and upon the International Law Association for the formulation of an International Convention, and eventually the Harter Act formula was modified and adopted as the Hague Rules, 1921. These Rules were revised at Brussels in 1924, and were recommended for adoption by the various maritime nations. In the United States, oppo-

[18] Gilfillan, Inventing the Ship (1935); 3 Wigmore, A Panorama of the World's Legal Systems c. XII, at 875 (1928), says that the oldest picture of a sea-going ship of large size is the sculptured ship of Queen Hatshepsut in Egypt about 1500 B.C., who, as a princess, discovered the infant Moses in the bulrushes and saved him to become the Hebrew leader. Will Cuppy, who carefully researched the reign of Queen Hatshepsut, does not mention that incident but describes her maritime interests in Cuppy, The Decline and Fall of Practically Everybody 23 (1950), as follows: "One of the main events of Hatshepsut's reign was the voyage to Punt, or Somaliland, for things to use in the temple services and in the terraced gardens of Amon. Five small vessels went down the Red Sea in 1492 B.C. and returned with thirty-one living myrrh trees, many other varieties of odoriferous and ornamental plants, myrrh resin, ihmut incense, cinnamon wood, Khesyt wood, ebony, ivory, gold, electrum, more than three thousand animals, including greyhounds, monkeys, and a giraffe, some Punties, a collection of native throw sticks, and several unidentified objects." We have found no published tariff rates on most of these items from the manifest so they will be classified as "commodities generally NOIBN."

[19] WPA, A Maritime History of New York 151 (1941). One of our most enterprising vessel owners, named Preserved Fish, called his fastest packet boat George Washington, entered it in the race of twelve British and American commercial vessels between New York and Liverpool in 1835, and won. Today the Mayor of Chicago gives a prize for the first European vessel to reach Chicago each spring.

[20] Dugan, The Great Iron Ship (1953).

[21] *Lucking v. Detroit & Cleveland Nav. Co.*, 265 U.S. 346, 44 Sup. Ct. 504 (1924).

[22] *Propeller Niagra v. Cordes*, 62 U.S. (21 How.) 7, 23 (1859).

[23] 27 STAT. 445 (1893), 46 U.S.C.A. §§ 190-93 (1958).

[24] *Koppers Connecticut Coke Co. v. James McWilliams Blue Line*, 89 F.2d 865 (2d Cir. 1937).

sition from cargo interests prevented adoption until 1936 when the Hague Rules of 1921 and Brussels Convention of 1922-1924, with certain understandings, were ratified by the United States and enacted into law as the Carriage of Goods by Sea Act (known as, and hereafter referred to as Cogsa) in 1936.[25] The "Clause Paramount" of this act provides: "That every bill of lading or similar document of title which is evidence of a contract for the carriage of goods by sea to or from ports of the United States, in foreign trade, shall have effect subject to the provisions of this Act." Legislation similar to Cogsa has been enacted by most of the maritime nations so there is today a reasonable degree of uniformity in ocean bills of lading.[26]

Under Cogsa, a carrier is not an insurer but has a statutory duty to use due diligence to make the ship seaworthy, properly to man, equip, and supply it, and to make the holds and all other parts of the ship where goods are carried fit and safe for their reception, carriage, and preservation.[27] The carrier is not liable for loss resulting from unseaworthiness if due diligence has been exercised, but the burden of proving due diligence is on the carrier.[28] Cargo owners can recover for losses caused by unseaworthiness unless due diligence was exercised. Cogsa also provides that the carrier shall properly and carefully load, handle, stow, carry, keep, care for, and discharge the goods carried.[29]

On the other hand, section 4 (2) of Cogsa contains a list of causes for which the carrier shall not be liable. The most important of these is the immunity from loss caused by "act, neglect, or default of the master, mariner, pilot, or the servants of the carrier in the navigation or in the management of the ship." Thus, the carrier is not liable for losses due to negligent navigation but is liable for failure to care properly for cargo during the voyage. The line between these two concepts is not always easy to draw and has been the subject of considerable court interpretation.[30] Cogsa is of greater protection to a carrier than was the Harter Act principally because the exemption for negligent navagation under the latter was only available if the carrier had used due dilligence to make the vessel seaworthy, whether there was or was not causal connection between the unseaworthiness and the loss.[31]

So it is that the carrier exemptions of Cogsa, incorporated into all foreign trade bills of lading, protect the carrier in proper circumstances from liability for losses due to fire, perils of the sea, negligent navigation, Acts of God, and other causes arising without the actual fault or privity of the carrier. Shippers universally carry cargo insurance so they recover their losses from that source whether or not the cargo insurer can legally collect from the carrying vessel. It is interesting to note that section 3 (8) of Cogsa outlaws the benefit of insurance clause, so there is no need for cargo underwriters to advance loss payments under loan receipt to their assureds, a practice which is lawful and proper under Harter Act bills of lading.[32] Cogsa applies to common carrier liner service; and it also applies to tramp shipping if the tramp carrier issues bills of lading instead of chartering the vessel's space to the shipper. By express agreement Cogsa may be made applicable to an affreightment charter although it does not so apply of its own force.[33] Transportation service under a time charter, also called an affreightment charter, in which the vessel owner operates the vessel but rents out the cargo space, is generally considered private carriage as to which there are no statutes similar to Cogsa governing the terms of the contract. Under the general maritime law, however, there is an implied warranty of seaworthiness in charter parties, just as there was under bills of lading issued by common

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[25] 49 STAT. 1207-13 (1936), 46 U.S.C.A. §§ 1300-15 (1958).

[26] KNAUTH, THE AMERICAN LAW OF OCEAN BILLS OF LADING 99 (1953), contains a careful commentary on the movement for uniformity in ocean bills of lading. See also GILMORE & BLACK, THE LAW OF ADMIRALTY 122 (1957); MORRISON AND STUMBERG, CASES ON ADMIRALTY 315 (1954), and cases cited in each of these texts. Revival of the international viewpoint in maritime law is explained in a general and interesting manner in 3 WIGMORE, A PANORAMA OF THE WORLD'S LEGAL SYSTEMS 920 (1928).

[27] 49 STAT. 1208 (1936), 46 U.S.C.A. §§ 1303 (1) (1958).

[28] *Id.* at 1210, 46 U.S.C.A. § 1304 (1).

[29] *Id.* at 1208, 46 U.S.C.A. § 1303 (2).

[30] *Knott v. Botany Worsted Mills*, 179 U.S. 69, 21 Sup. Ct. 30 (1900). KNAUTH, *op. cit. supra* note 26, contains a collection of decisions on the distinction between "navigation and management" and "care and custody."

[31] *The Isis*, 290 U.S. 333, 54 Sup. Ct. 162 (1933).

[32] *Luckenbach v. W. J. McCahan Sugar Co.*, 248 U.S. 139, 39 Sup. Ct. 53 (1918).

[33] *United States v. The South Star*, 210 F.2d 44 (2d Cir. 1954).

carriers prior to Cogsa.[34] The extent to which this warranty may be limited by the contract, the question as to burden of proof, and the requirement of seaworthiness for specific types of cargoes are all interesting questions that will continue to be litigated.[35]

### Vessel and Crew

*Foreign Consuls; Internal Economy of Vessels; Seamen's Wages*

We turn now from the relations of vessel and cargo to those of vessel and its personnel, which are becoming more and more complex. When an American vessel arrives in a foreign port and reports to the American consul, the latter must certify as to any desertions, discharges, or hirings of seamen. The consul is charged with the duty of enforcing the navigation laws as to payment, care, hiring, discharge, and repatriation of seamen in foreign ports. Before the vessel returns to the United States from a foreign port the master is responsible for securing consular and local bills of health and clearance, and he must have possession of the vessel's documents. American consular officers deal with disputes on board American vessels which concern the internal order therof, such as disputes over wages of seamen and seamen's caveats as to safety or seaworthiness of the vessel. Before marine inspection was so thorough as it is today, many an old wooden crate was surveyed at the direction of an American consul upon request of the crew. In any case the rights of seamen of an American ship to make complaints to representatives of the United States in foreign ports have been long and carefully protected.[36] Alien seamen in our ports have somewhat similar rights with respect to the consular officials of the country whose flag the ship flies. We have treaties with the other maritime nations on these matters which are by no means uniform, but many of the older treaties give consular officers the right to act as judges or arbiters in such differences as arise between the master and crew, without interference from local courts or other local authorities. As to controversies arising in American ports, where jurisdiction of consuls in these matters is made exclusive by treaty provision, the courts of the United States will not ordinarily take jurisdiction.[37] *Ex Parte Anderson*[38] involved a master's discipline of a seaman on a Norwegian vessel in which the court decided that it could not prosecute the master because of the internal economy clauses of the treaty. Many of our maritime treaties are quite ancient. However, some of the more modern treaties concluded since World War I provide that the authority of the consul shall go no futher than local law may permit.[39] Other treaties have provided for concurrent jurisdiction of consuls and local courts, thereby enabling local courts either to decline jurisdiction where appropriate or to hear the case. The decisions on the question of discretionary jurisdiction are interesting but not uniform.[40]

Congress has adopted comprehensive legislation to protect American seamen and some of this applies to alien seamen as well. These statutes deal with shipment of seamen, contracts of employment called shipping articles, time for payment of wages, accounting as to wages, continuous records of employment, crew quarters, medicines, nationality of crews, and offenses committed by seamen.[41] The La Follette Seamen's Act of 1915,[42] in its section 4, provides that every seaman on a vessel of the United States shall, upon request, be paid one-half of his accrued wages at each port where cargo is loaded or discharged, that stipulations in contracts that are to the contrary shall be void, that United States courts shall have jurisdiction, and that this section shall apply to seamen on foreign vessels while in harbors of the United States. This section was contrary to some of our treaties, thereby leading to some confusion, but notice of termination, in whole or in part of various treaties was given by our

[34] *The Caledonia*, 157 U.S. 124 (1895); *Work v. Leathers*, 97 U.S. 379 (1878); *Jordan, Inc. v. Mayronne Drilling Serv.*, 214 F.2d 410 (5th Cir. 1954); *New England S.S. Co. v. Howard*, 130 F.2d 354 (2d Cir. 1942).

[35] Gilmore & Black, The Law of Admiralty 182-83 (1957).

[36] 1 Norris, Law of Seamen 34 (1952).

[37] *Id.* at 65.

[38] 184 Fed. 114 (D. Me. 1910). See *The Cambitis*, 14 F.2d 236 (E.D. Pa. 1926); *The Bound Brook*, 146 Fed. 160 (D. Mass. 1906); *The Marie*, 49 Fed. 286 (D. Ore. 1892).

[39] 1 Norris, Law of Seamen 63 (1952).

[40] *The Belgenland*, 114 U.S. 355, 5 Sup. Ct. 860 (1885); *Lakos v. Saliaris*, 116 F.2d 440 (4th Cir. 1940), *The Estrella*, 102 F.2d 736 (3d Cir. 1938).

[41] Much of this material is contained in 46 U.S.C.A. §§ 541-681 (1958).

[42] 38 Stat. 1164 (1915), 46 U.S.C.A. § 597 (1958). In 38 Stat. 1169 (1915), 46 U.S.C.A. § 601 (1958), there is an interesting provision for seamen's protection, that seamen's wages are not subject to attachment or garnishment, and may not be assigned prior to the accruing thereof.

government.[43] Some treaties have been amended to conform to the La Follette Seamen's Act. Even aside from termination of inconsistent treaty provisions, the United States Supreme Court held in several cases that the statute prevails over the treaty because Congress can prescribe the conditions which attend the entrance of foreign vessels into our ports.[44] Our courts will take jurisdisction upon petitions of a foreign consul to arrest and imprison seamen charged with crimes committed in the foreign country in order that they may be removed from the foreign flag vessel in a United States port for the purpose of repatriation.[45] Of course, acts done ashore by alien seamen are subject to the jurisdiction of our courts where they effect the order and tranquility of our country and do not pertain solely to the internal order and economy of the vessel. A serious crime such as murder, even though committed by an alien on board a foreign vessel in a United States port, is subject to prosecution here.[46]

### *Personal Injuries Suffered by Foreign Seamen*

Alien seamen serving on foreign vessels have sometimes filed suits in our courts for personal injuries even though they may be entitled to workmen's compensation, without proof of negligence, under the law of the vessel's flag. Many maritime nations have workmen's compensation laws applicable to seamen which do not require proof of negligence in order for a seamen to recover damages as does our Jones Act.[47] Although the usual procedure is for the alien seamen to return to the appropriate foreign jurisdiction, and our courts are under no obligation to entertain jurisdiction, they have often assumed jurisdiction in such disputes between a foreign seaman and a foreign shipowner if a refusal to hear the case would result in undue hardship or denial of justice.[48] The foreign law is usually proved and applied instead of our own substantive law, although in cases where the general principles of the foreign substantive law are comparable to our own, the courts often consider our local precedents, for example, in determining an amount to be awarded for pain and suffering.[49] There is some authority for the proposition that our law will be applied whenever any one of these elements is present: (a) the seaman is an American citizen; (b) the vessel is registered under the American flag; or (c) the vessel is owned by American citizens.[50]

### *Foreign Seamen Under the Jones Act*

The leading case on whether or not the Jones Act can be applied is *Lauritzen v. Larsen*,[51] decided by the Supreme Court in 1953. In this case Larsen, a Danish seaman temporarily in New York, joined the crew of the "Randa," a Danish flag vessel owned by a Danish citizen. The articles which Larsen signed provided that rights of crew members would be governed by Danish Law. While in Havana Harbor, Larsen was injured as the result of negligence of the shipowner, whereupon he filed suit in a United States district court at law with request for a jury trial. The defendant contested the jurisdiction of the court and the applicability of the Jones Act. It was shown that Denmark has a comprehensive code which protected Larsen's rights as a seaman, and that our Jones Act conflicts with the policy of the Danish law. Denmark provides maintenance and cure for a fixed period of time and then workmen's compensation for disability, neither of which is dependent upon proof of negligence. In a careful and thorough opinion, Mr. Justice Jackson discussed the weight to be accorded to the various contacts which might be relevant for the court to consider in making a decision as to what law will apply. These considerations were: (1) the

[43] *Romero v. International Terminal Operating Co.*, 244 F.2d 409 (2d Cir. 1957); 1 NORRIS, LAW OF SEAMEN 95 (1952).

[44] *Strathearn S.S. Co. v. Dillon*, 252 U.S. 348, 40 Sup. Ct. 350 (1920); *Patterson v. The Bark Eudora*, 190 U.S. 169, 23 Sup. Ct. 821 (1903).

[45] *Petition of Therianos*, 171 F. 2d 886 (3rd Cir. 1948).

[46] *Wildenhus Case*, 120 U.S. 1, 7 Sup. Ct. 385 (1887).

[47] 41 STAT. 1007 (1920), 46 U.S.C.A. § 688 (1958).

[48] *Plamals v. The Pinar Del Rio*, 277 U.S. 151, 48 Sup. Ct. 457 (1928); *Heredia v. Davis*, 12 F.2d 500 (4th Cir. 1926); *Samad v. Etivebank*, 134 F. Supp. 530 (E.D. Va. 1955); *Cruz v. Harkana*, 122 F. Supp. 288 (S.D.N.Y. 1954).

[49] *Fletero v. Arias*, 206 F.2d 267 (4th Cir. 1953) (Argentine seamen recovered on theory of unseaworthiness); *Markakis v. Liberian*, 161 F. Supp. 487 (S.D.N.Y. 1958) (Greek seaman signed articles in Germany, was injured in United States aboard vessel owned by Panamanian corporation flying Liberian flag, recovered under Liberian substantive law enforced in U.S. district court); *Samad v. Etivebank, supra* note 48 (Pakistan seaman recovered under British flag substantive law, but damages for pain and suffering measured by American law).

[50] Decisions on these varying situations are discussed in GILMORE & BLACK, THE LAW OF ADMIRALTY 388 (1957); 1 NORRIS, LAW OF SEAMEN 670-81 (1952).

[51] 345 U.S. 571, 73 Sup. Ct. 921 (1953).

place where the tort was committed; (2) the flag of the vessel; (3) the domicile of the seaman; (4) the nationality of the shipowner; (5) the place where the articles were signed; (6) the inaccessability of the foreign court; (7) the law of the forum. The court held that the Jones Act was not applicable on the particular facts of that case. The opinion stated:

> "We do not question the power of Congress to condition access to our ports by foreign-owned vessels upon submission to any liabilities it may consider good American policy to extract. But we find no justification for interpreting the Jones Act to intervene between foreigners and their own law because of acts on a foreign ship not in our waters."[52]

The question among others, was passed upon again by the United States Supreme Court in a decision announced on February 24, 1959, in the case of *Romero v. International Terminal Operating Co.*[53] This *Romero* case was a suit under the Jones Act brought by a Spanish seaman, under Spanish articles against a Spanish vessel for an injury which occurred in an American port. The district court rendered an elaborate opinion and dismissed the complaint. The court of appeals affirmed on the basis of the district court's opinion but also considered whether or not the treaty with Spain gave the Spanish seaman any substantive rights. The Supreme Court decision followed *Lauritzen v. Larsen* in holding that the Jones Act did not apply. This decision is much more significant for reasons other than its determination that the Jones Act does not apply to the injury of a foreign seaman in American waters under these circumstances. The majority opinion of Mr. Justice Frankfurter thoroughly deals with the question whether an admiralty case is within federal jurisdiction on the law side of the court under 28 U.S.C. § 1331 as a cause arising "under the Constitution, laws, or treaties of the United States." He holds that it is not such a cause. But the suit as to the three defendants other than the Spanish shipowner are sustained because of diverse citizenship and possibly "pendent jurisdiction." These counts, therefore, were sent back to the district court for trial, but the majority opinion says, "We are not called upon to decide whether the district court may submit to the jury the 'pendent' claims under the general maritime law in the event that a cause of action be found to exist."

Mr. Justice Brennan wrote a vigorous dissent. He would have sustained jurisdiction under sections 1331 and 1332 (on the basis of diversity) but would not apply the Jones Act here. Mr. Chief Justice Warren joined in this dissent. Mr. Justice Black agreed with the Brennan dissent but would have gone farther and would have allowed the suit of shipowner under the Jones Act. Mr. Justice Douglas agreed with the Black dissent except that he thought the facts here distinguished the case from *Lauritzen v. Larsen,* whereas Mr. Justice Black expressed the belief that that decision was wrong, too. This case has properly settled some points while opening up some new uncertanties. We shall have to watch with interest what the future holds for the idea of "pendent jurisdiction."

*American Seamen Yesterday and Today*

In American admiralty law seamen have always been entitled to receive maintenance and cure if they are injured or become sick while they are employees. This right is not dependent upon negligence or upon the disability being related to shipboard duties, but is not given if caused by the seaman's own willful misconduct. One of the earliest American legal explanations of the shipowner's duty to provide maintenance and cure is Judge Story's long opinion rendered in 1823 in the case of *Harden v. Gordon.*[54] This was a libel for subtraction of wages and for expenses of a seaman's illness in a foreign port. The ship's articles contained a clause that the crew agree to pay for all medicines and all medical aid beyond what the medicine chest afforded. Judge Story allowed recovery of both claims, discussed maintenance and cure, and then made the oft quoted statement:

> "Every court should watch with jealousy an encroachment upon the rights of seamen, because they are unprotected and need counsel; because they are thoughtless and require indulgence; because they are credulous and complying; and are easily overreached. But courts of maritime law have been in the constant habit of extending towards them a peculiar, protecting favor and guardianship. They are emphatically the wards of the admiralty; and though not techni-

[52] *Id.* at 592-93, 73 Sup. Ct. at 933.
[53] 358 U.S. 354, 79 Sup. Ct. 468 (1959).
[54] 11 Fed. Cas. 480 (No. 6047) (D. Me. 1823).

cally incapable of entering into a valid contract, they are treated in the same manner, as courts of equity are accustomed to treat young heirs, dealing with their expectancies, wards with their guardians, and cestuis que trusts with their trustees."[55]

The days of hard tack and lime juice, of short and wormy rations, have gone the way of the sailing vessels; the unhappy crimp, the cat of nine tails, and Captain Bligh[56] are only found in funny song or in interesting movies which modern sailors see during their modern voyages. Lumberjacks were a class of rough and ready, hard-boiled fellows, too, but they never were compared to young heirs needing a guardian. Somebody would have been shot.[57] A seaman today would not recognize a vessel of *circa* 1823 when Judge Story called seamen what he did in *Harden v. Gordon,* but the legal principle lingers on.[58] Just as science and engineering have changed the nature of vessels, so have education and social legislation changed the nature and the duties of the average man who serves on an American vessel, not to mention what the labor union does in collective bargaining and in other directions. Yet there is a cultural lag in the retention of the idea that the seaman is a "ward" which has enabled some seamen to have their own releases set aside[59] and has made it possible for others to build up damage claims in litigation based on most extraordinary allegations of either negligence or unseaworthiness.[60] Also there are maintenance awards in some strange situations.[61] Aside from maintenance and cure, there have been so many changes in the rights of seamen and other maritime workers in the last forty years that a careful look at one of the famous cases is in order. That case is *The Osceola,*[62] decided by the Supreme Court in 1902. Here the libelant was an injured seaman who alleged that an improvident order of the master to raise the gangway by using a derrick while the vessel was under way in a strong wind caused the derrick to fall and injure libelant. There was no unseaworthiness charged nor indicated in the proofs. The suit was for damages and for maintenance and cure. After review of American and foreign authorities Mr. Justice Brown made this classic summary of the law of seamen:

"Upon a full review, however, of English and American authorities upon these questions, we think the law may be considered as settled upon the following propositions:

"1. That the vessel and her owners are liable, in case a seaman falls sick, or is wounded, in the service of the ship, to the extent of his maintenance and cure, and to his wages, at least so long as the voyage is continued.

"2. That the vessel and her owner are, both by English and American law, liable to an indemnity for injuries received by seamen in consequence of the unseaworthiness of the ship, or a failure to supply and keep in order the proper appliances appurtenant to the ship.

"3. That all the members of the crew, except, perhaps, the master, are, as between themselves, fellow servants, and hence seamen cannot recover for injuries sustained through the negligence of another member of the crew beyond the expense of his maintenance and cure.

"4. That the seaman is not allowed to recover an indemnity for the negligence of the master, or any member of the crew, but is entitled to maintenance and cure, whether the injuries were received by negligence or accident."[63]

Of course, a lot of water has gone under the bridge since these principles were expressed in 1902.

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[55] *Id.* at 485.

[56] DANA, TWO YEARS BEFORE THE MAST (1840); MELVILLE, MOBY DICK c. 33 (1834); DUGAN, THE GREAT IRON SHIP (1953).

[57] HOLBROOK, HOLY OLD MACKINAW 43, 92, 258 (1957).

[58] *Farrell v. United States,* 336 U.S. 511, 69 Sup. Ct. 707 (1949).

[59] *Garrett v. Moore McCormack Co.,* 317 U.S. 239, 63 Sup. Ct. 246 (1942).

[60] *Repsholdt v. United States,* 205 F.2d 852 (7th Cir. 1953).

[61] *Loistenen v. American Export Lines,* 83 N.Y.S.2d 297 (1948). A seaman on shore leave jumped out of the window of a woman's apartment when a man, presumably her husband, showed up suddenly. He broke a leg, for which he recovered maintenance and cure from his employer. Professor Brainerd Currie of the University of Chicago Law School has briefed this case in poetry. The following is a sample stanza:

"Carlin, J., presided and he saw the issue clear,
He had the glitt'ring vision of a bright-eyed mariner;
I know Eino was naughty, I know he made a slip,
But all that Eino did was in the service of the ship."

[62] 189 U.S. 158, 23 Sup. Ct. 483 (1903).

[63] *Id.* at 175, 23 Sup. Ct. at 487.

The LaFollette Seamen's Act, section 20, attempted to abolish the fellow servant doctrine.[64] But the Supreme Court held in *Chelentis v. Luckenback S.S. Co.*[65] that regardless of the fellow servant rule there could be no recovery for injury caused by negligence of the master or crew, and that there is a distinction between negligence and unseaworthiness as a basis of recovery. At that time state workmen's compensation statutes were being held invalid as to marine workers, on the principle that this would violate the uniformity and harmony of the admiralty law, in *Southern Pacific v. Jensen*[66] and the line of cases which followed. Accordingly, in 1920 Congress adopted the Jones Act[67] and in 1927 the Longshoremen and Harbor Workers' Compensation Act.[68] These cases and these statutes represent high spots in volumes of long, intricate, and involved reasoning, and and a generation or more of litigation when it would have been preferable for a seaman to receive workmen's compensation than to have a claim which had to be supported by proof of negligence. The world of the seaman and of the shipowner is out of joint today. There seems to be no common-sense common ground such as might be achieved through passage of an adequate Federal Compensation Act for seamen and repeal of the Jones Act. Two of the important aspects of this problem in today's litigation are: (1) what evidence will be sufficient to raise a jury question as to negligence, and (2) whether or not a worker is a seaman. The Supreme Court has reviewed many cases on these points in the past decade. It has held that if a sea cook cuts his hand with a butcher knife while serving ice cream it is a jury question as to whether or not the shipowner is at fault for not providing something more powerful than the usual ice cream scoop for use when ice cream has been left too long in a deep freeze.[69] It is a jury question whether a land-based laborer on a suction dredge attached to shore is a seaman,[70] or if the operator of a pile driver on a Texas tower fastened firmly to the bottom is a seaman.[71]

The foreign shipowner, equally with the American, is in a state of confusion about longshoremen and other maritime workers who are not seamen but are employed by independent contractors to work on board a vessel. They are entitled to compensation irrespective of fault under the Longshoremen's Act but may elect to sue third-party tortfeasors. In case of injury on board a vessel, suit is often filed alleging an absolute duty to provide a seaworthy vessel, and a breach thereof. The development of the law in this field is another long story, but it can be summarized. There was dicta in *The Osceola*[72] that a seaman can recover damages if injured as the result of an unseaworthy condition. In 1944 the case of *Mahnich v. Southern S.S. Co.*[73] held that this liability was absolute whether the shipowner was at fault or not. In 1946, *Seas Shipping Co. v. Sieracki*[74] extended this right to a longshoreman, who was entitled to compensation from his employer's insurance carrier but who had sued the vessel owner as a third-party tortfeasor. Then in 1952 *Halcyon Lines v. Haenn Ship Ceiling & Refiting Co.*[75] held that where the shipowner and the stevedore contractor are both at fault for the longshoreman's injury there can be no contribution; the shipowner pays. *Pope & Talbot v. Hawn*[76] says that contributory negligence under state law is no defense even where the action is in the state court. In 1956 came *Ryan Stevedoring Co. v. Pan Atlantic Steamship Co.*,[77] holding that where the unseaworthy condition was caused by the stevedore contractor, and where the shipowner was liable because of his non-delegable duty to provide a seaworthy vessel, the shipowner may recover indemnity from the stevedore contractor. This, it was held, differs from contribution among joint tortfeasors and is based on an implied contract safely to load or unload a vessel. So the stevedore contractor pays the damages despite the Longshoremen's Act which says that his only liability shall be to provide compensation. This is a logical result of the expansion of the seaworthiness obligation, as occurred in *Mahnich v. Southern S.S. Co.* It is now clear

[64] 38 STAT. 1185 (1915).
[65] 247 U.S. 372, 38 Sup. Ct. 501 (1918).
[66] 244 U.S. 205, 37 Sup. Ct. 524 (1917).
[67] 41 STAT. 1007 (1920), 46 U.S.C.A. § 688 (1958).
[68] 44 STAT. 1424-46 (1927), 33 U.S.C.A. §§ 901-48 (1957). See *Davis v. Department of Labor*, 317 U. S. 249, 63 Sup. Ct. 225 (1942), for "twilight zone" between federal and state compensation acts.
[69] *Ferguson v. Moore-McCormack Lines Inc.*, 352 U.S. 521, 77 Sup. Ct. 457 (1957).
[70] *Senko v. LaCrosse Dredging Corp.*, 352 U.S. 370 77 Sup. Ct. 415 (1957).
[71] *Grimes v. Raymond Concrete Pile Co.*, 356 U.S. 252, 78 Sup. Ct. 687 (1958).
[72] 189 U.S. 158, 23 Sup. Ct. 483 (1903).
[73] 321 U.S. 96, 64 Sup. Ct. 455 (1944).
[74] 328 U.S. 80, 66 Sup. Ct. 872 (1946).
[75] 342 U.S. 282, 72 Sup. Ct. 277 (1952).
[76] 346 U.S. 406, 74 Sup. St. 202 (1953).
[77] 350 U.S. 124, 76 Sup. Ct. 232 (1956).

that where the stevedores bring into play an unseaworthy condition, no matter how the unseaworthiness originated, a shipowner that is held liable to the longshoreman may recover over against the stevedore. This is the decision in *Crumady v. Joachim Hendrik Fisser* announced by the Supreme Court on February 24, 1959.[77a]

Since January 1959, a new element of uncertainty must be dealt with, at least in the State of Oregon. The Supreme Court allowed a worker on a gravel barge who was injured on navigable water to recover under common-law negligence principles, the employer having provided insurance only under the Longshoremen's Act and not under the Oregon Workmen's Compensation Act.[78] The work was said to be maritime but local, within the "twilight zone," where state workmen's compensation could validly be provided by state law under the *Jensen* rule. Heretofore, as stated in Justice Stewart's dissent, no one supposed that either *Davis v. Department of Labor*[79] or the federal statute allowed an employee to spurn federal compensation and submit his claim to a state court. The whole subject of the rights of marine workers, which became more and more confused after *Mahnich v. Southern S.S. Co.*,[80] is in a state of involution such as never before existed, and we are awaiting further expressions from the courts and from the Congress. This ancient, stable, not to say moth-eaten, subject of maritime law has been turned inside out and shaken with a vengenance.

## The Vessel

### *Maritime Liens*

Courts and text book writers have said that a vessel has a personality of its own, because it may incur liabilities represented by maritime liens while its owner remains faultless,[81] and the vessel may be sued either with or without its owner as a party litigant. The maritime lien is a secret lien, not requiring the lienor to have possession, but it loses priority to later leins if not seasonably enforced. Unless barred by laches it will remain valid in the hands of a bona fide purchaser. Common-law proceedings will not divest the vessel of a maritime lien and it may be enforced only by a proceeding in rem in admiralty. Such liens arise out of contracts and torts, provided they are maritime and involve the vessel itself as distinguished from the business generally of the shipowner.[82] There is a morass of court decisions on the subject of lien priorities which can be researched by any one having time on his hands.[83] During the depression of the 1930's this phase of law was exercised vigorously, but in today's brisk inflationary times the importance of lien priority has receded. Under the lien statute of 1910, as amended in 1920,[84] any person will have a lien for furnishing repairs, supplies, towage, use of dry dock, or other necessaries to a vessel on order of someone having authority from the owner, or on the order of a person to whom the management of the vessel at the port of supply is entrusted. It seems that if a charter party contains a positive prohibition against a charter incurring liens, such a restriction will be upheld.[85]

### *Collision*

The International Rules,[86] applicable on the high seas, and the Rules for the Great Lakes and their Connecting and Tributory waters,[87] must be accurately and intelligently followed, for if a rule is violated and a collision occurs, a heavy burden is placed upon such vessel to show that the violation could not have contributed to the disaster.[88] Very frequently in collision cases there is fault on the part of both vessels. The doctrine in American admiralty courts has been long established that damages are equally divided in such mutual fault situations.[89] Most of the other maritime nations have ratified the Brussels Convention

[77a] 358 U.S. 423, 79 Sup. Ct. 445 (1959).

[78] *Hahn v. Ross Island Sand & Gravel Co.*, 358 U.S. 272, 79 Sup. Ct. 266 (1959).

[79] 317 U.S. 249, 63 Sup. Ct. 225 (1942).

[80] 321 U.S. 96, 64 Sup. Ct. 455 (1944).

[81] *Homer Ramsdell Tr. Co. v. La Compagnie General Transatlantique*, 182 U.S. 406, 21 Sup. Ct. 831 (1901); *The China*, 74 U.S. 53 (1868). See discussion of liens in Gilmore & Black, The Law of Admiralty c. IX (1957).

[82] *Piedmont & George's Creek Coal Co. v. Seaboard Fisheries Co.*, 254 U.S. 1, 41 Sup. Ct. 1 (1920).

[83] Robinson, Admiralty Law 357-466 (1939), ably summarizes the authorities on this subject of maritime liens.

[84] 41 Stat. 1005 (1920), 46 U.S.C.A. §§ 971-75 (1958).

[85] *Dannebrog v. Signal Oil & Gas Co.*, 310 U.S. 268, 60 Sup. Ct. 937 (1940); *United States v. Carver*, 260 U.S. 482, 43 Sup. Ct. 181 (1923).

[86] 65 Stat. 408 (1954), 33 U.S.C.A. §§ 144-47d (1957).

[87] 28 Stat. 645 (1895), 33 U.S.C.A. §§ 241-95 (1957).

[88] *The Pennsylvania*, 125 U.S. 125 (1873).

[89] *The Max Morris*, 137 U.S. 1, 11 Sup. Ct. 29 (1890).

of 1910,[90] which adopts a comparative negligence rule to determine damages according to degrees of fault; but we have not ratified this convention and, therefore, this rule is not followed as to collisions in American waters. Maritime liens on offending vessels can be enforced by libels in rem, in personam, or both. A vessel that is libelled in a collision case usually files a cross libel in order that its own damages may be taken into consideration by the court.[91] There are occasional cases in which the vessel may be liabel in rem without any liability of an owner or bare boat charterer, as for instance if the fault is that of a compulsory pilot.[92] In personam liability of a shipowner may be enforced in a common-law court, but this remedy is rarely pursued because the Supreme Court in *Belden v. Chase*[93] said that the common-law rule of contributory negligence, not followed in admiralty, will nevertheless bar recovery in a common-law court. It is probable that the rule of that case will be overthrown when it next comes before the Supreme Court, if it is not already gone, there being dicta against it in several cases not involving collision[94] which may also be applicable to collision cases.

*Limitation of Liability*

In order to encourage American shipping to put us on a competitive footing with Great Britain, and in order to do what some other maritime nations had done, Congress in 1851 adopted a loosely phrased limitation of liability law,[95] patterned after a statute of the State of Maine, but in principle like British law. This act was practically a dead letter for twenty years and was then construed in *Norwich & N.Y. Transportation Co. v. Wright*,[96] in an opinion which took up the history of the limitation principles and stated their purposes in the American scheme of maritime commerce. The act has been amended several times and the procedure to be followed is set forth in the Admiralty Rules of the Supreme Court. In general, it enables a shipowner whose managing officers are not at fault to limit his liability to the value of what remains of the vessel plus her pending freight. As to loss of life and personal injury claims on certain types of vessels, the ship owner must provide a fund equal to $60 per gross ton of the vessel's registered tonnage, pursuant to a 1935 amendment. This limitation law has been amended several times since 1871 and has been liberally construed in numerous decisions which recite its purpose to encourage investment in vessels. What constitutes "privity and knowledge" that will defeat limitation has been litigated extensively so that there are many decisions which attempt to define this phrase.[97] Foreign vessels can avail themselves of this law as stated in *The Titanic*[98] and as later provided specifically by one of the 1935 amendments to the statute. A celebrated limitation case grew out of the 1915 capsizing of the "Eastland" in the Chicago River with the loss of about 800 lives. Limitation was granted but twenty years of litigation had ensued before the final limitation decree was entered.[99]

Under the limitation of liability laws, a shipowner surrenders the vessel or its value after the accident but need not surrender the proceeds of insurance; nor is the liability insurance of the shipowner available for payment of claims beyond the amount of the limitation fund, if the shipowner is granted a decree of limitation. This rule as to insurance stems from the *City of Norwich*,[100] where the Supreme Court said that a shipowner should be permitted to contract with his insurance company for indemnity against loss of his investment. This principle has been threatened, if not severely shaken, by an interpretation of the Louisiana direct action statute which authorized suits against liability insurers by injured claimants. This interesting case is *Maryland Casualty Co. v. Cushing*,[101] which was before the Supreme Court in 1954 but was sent back to the district court so that the question of direct action would await

[90] See ROBINSON, ADMIRALTY 854 (1939), for a discussion of the Brussels Convention.
[91] *Reynolds v. Vanderbilt (The North Star)*, 106 U.S. 17, 1 Sup. Ct. 41 (1882).
[92] *Homer Ramsdell Tr. Co. v. La Compagnie Gen. Transatlantique*, 182 U.S. 406, 21 Sup. Ct. 831 (1901); *The China*, 74 U.S. 53 (1868).
[93] 150 U.S. 674, 14 Sup. Ct. 264 (1893).
[94] *Pope & Talbot, Inc. v. Hawn*, 346 U.S. 406, 74 Sup. Ct. 202 (1953); *W. E. Hedger Transp. Corp. v. United Fruit Co.*, 198 F.2d 376 (2d Cir. 1952).
[95] REV. STAT. § 4281 (1875), 46 U.S.C.A. § 181-89 (1958).
[96] 80 U.S. (13 Wall.) 104 (1871).
[97] *The Seminole*, 317 U.S. 406, 63 Sup. Ct. 291 (1943); *The Linseed King*, 285 U.S. 502, 52 Sup. Ct. 450 (1932); *Hutchinson v. Dickie*, 162 F.2d 103 (6th Cir. 1947); *The Cleveco*, 154 F.2d 605, (6th Cir. 1946).
[98] 233 U.S. 718, 34 Sup. Ct. 754 (1914).
[99] The Eastland, 78 F.2d 984 (7th Cir. 1935).
[100] 118 U.S. 468, 6 Sup. Ct. 1150 (1886).
[101] 347 U.S. 409, 74 Sup. Ct. 608 (1954).

completion of the proceeding in which the shipowner was seeking to limit liability. The Supreme Court was divided 4-4-1, that is to say, four favored denying direct action, four favored immediate recovery under the direct action law, and one favored a policy of wait and see. Therefore, the only way to break the deadlock was to send the case back in accordance with the opinion of the single justice who wanted to be sure that the direct action should not interfere with the federal limitation proceeding. One cannot say with any great assurance what the *Cushing* case stands for, although there is an opportunity for proctors to do some intelligent guessing in several directions.

### Admiralty Procedure in General

Section 9 of the Judiciary Act of 1789, as amended in 1948 and 1949,[102] provides that United States district courts shall have original jurisdiction, exclusive of the courts of the states, of "any civil case of admiralty or maritime jurisdiction, saving to suitors in all cases all other remedies to which they are otherwise entitled." This statute implements the jurisdictional grant of article III, section 2 of the United States Constitution and also provides that suitors shall have alternative rights to pursue a common-law remedy in state courts. Prior to 1948 this "saving clause" provided that suitors should has the right to a "common-law remedy where the common law is competent to give it." The new language probably does not enlarge the jurisdiction of the state courts in comparison to the former saving clause. By broadly generalizing, it may be said that the enforcement of maritime liens remains exclusively in admiralty courts, that actions in personam may be filed either in admiralty in personam in a federal court, or at common law in the state court, or on the civil side of a federal court if in such latter case the requirements as to diversity of citizenship and jurisdictional amount exist. There are exceptions to this general statement resulting from special statutes such as the Ship Mortgage Act[103] and the Jones Act.

The Supreme Court promulgated the Rules of Practice in Admiralty and Maritime Cases,[104] which have the force of statute[105] and must be observed in admiralty cases in United States district courts and in the courts of appeal. District courts have also made rules to regulate their admiralty practice, several districts, including the Southern District of New York and the Northern District of Illinois, having undertaken to adopt the Federal Rules of Civil Procedure insofar as they are not inconsistent with statute or with the admiralty rules of the Supreme Court.[106] Civil actions in admiralty are commenced by the filing of a libel, which may be in rem, in personam, or both. Limitation of liability proceedings are started by a petition, following detailed procedures set out in the admiralty rules. The rules as to pleadings, practice and procedure in admiralty cases are not complicated. *Benedict on Admiralty*[107] contains a thorough discussion of jurisdiction and procedure together with many sample form of libels, answers, petitions, decrees, and other forms of practice. Civil cases of admiralty jurisdiction are tried by a federal judge without a jury, except that in certain situations involving interstate voyages on the Great Lakes a jury can be demanded.[108] This is due to a quirk in our law which arose in 1845 when Congress thought it necessary to extend admiralty jurisdiction to the Great Lakes by a special statute. The famous case of *The Genesee Chief v. Fitzhugh*[109] held that the constitution had already accomplished that extension beyond the ebb and flow of the tide, but the jury trial clause has never been repealed. It is inapplicable to international voyages, and the courts construe it strictly, for example, holding that it does not apply to maintenance and cure.[110]

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[102]62 Stat. 931 (1948), 63 Stat. 101 (1949), 28 U.S.C.A. § 1333 (1949).

[103]41 Stat. 1000 (1920), 46 U.S.C.A. §§ 911-61 (1958).

[104]Rev. Stat. § 913 (1875), 28 U.S.C.A. (1950).

[105]*The General Pershing*, 84 F.2d 273 (9th Cir. 1936).

[106]2 Benedict, The Law of Admiralty Par. 222b (6th ed. 1940). On March 31, 1959, the court of appeals, 7th Circuit, held in Atlass v. Miner, 265 F.2d 312, that local Admiralty Rule 32 of the District Court for the Northern District of Illinois is invalid, that it is inconsistent with the Supreme Court Admiralty Rules and that therefore discovery depositions provided for in Civil Rule 26 cannot be taken in admiralty cases. Despositions may be taken under the *de bene esse* Act (Rev. Stat. §§ 863-65 (1875), which may be found as a footnote in 28 U.S.C.A. § 1781. The *Atlass* opinion expresses the hope that the Supreme Court will amend the Admiralty Rules with congressional sanction.

[107]Benedict, The Law of American Admiralty (6th ed. 1940).

[108]62 Stat. 953 (1948), 28 U.S.C.A. § 1873 (1950).

[109]53 U.S. (12 How.) 466 (1851).

[110]*Miller v. Standard Oil Co.*, 199 F.2d 457 (7th Cir. 1952).

*Effect of State Statutes*

A phase of maritime practice which is far more complicated than pleadings in an admiralty case is the effect of state statutes upon maritime law and to what extent state courts may enforce rights against vessels. Some states have extensive legislation dealing with various aspects of shipping. Generally speaking, such statutes are invalid if in actual conflict with federal statutes or with general maritime law.[111] Where Congress has not spoken and the state act is not contrary to the uniformity of maritime law, a state statute on this subject will be valid.[112] Here again there is a "twilight zone"[113] of situations where the effect of state law is uncertain and must be determined case by case. Many state statutes that supplement the maritime law have been upheld, such as those giving a right of action for wrongful death,[114] giving liens on water craft if enforced in admiralty, and regulating the use of docks and harbors if not in conflict with federal laws or regulations.[115]

On the other hand, state workmen's compensation laws have been taboo for seamen and for other marine personnel unless perhaps they work in the "twilight zone," all of this stemming from the famous *Jensen* case,[116] which stated the principle that the admiralty law must be uniform in its application throughout the country. The application of that principle to workmen's compensation, as was done in that case, was unfortunate, but generally speaking, the principle is salutary. The latest landmark case on the subject of uniformity is *Wilburn Boat Co. v. Fireman's Fund Ins. Co.*[117] decided in 1955. That case held that a state statute which provided that the breach of a warranty in an insurance policy shall be no defense unless the breach thereof contributes to the loss, applied to a marine hull policy despite a long line of marine insurance precedents to the contrary. The opinion is long and involved, and there are several dissents, but the essence of the decision is expressed in the simple sentence, "In the field of maritime contracts as in the field of maritime torts the national government has left much regulatory power to the states." Without doubt there are areas in our maritime system which require clarification and uniform application through enactment of new federal laws, but no one can deny that at the present juncture the maritime law in this country presents some fascinating questions to be solved.

HARBORS AND IMPROVED CHANNELS; LOCAL, STATE, AND FEDERAL GOVERNMENTS

The federal government has paramount authority over the improvement of navigable streams and other navigable waters.[118] This control, as it relates to matters affecting navigation as distinguished from irrigation or fishing, for example, is delegated to a large extent to the Army Corps of Engineers.[119] In these matters the rights of the states are subservient to those of the United States, but agencies of both governments issue permits before marine construction or alterations of navigable channels commence. Where a state holds title to the bed of a lake it holds such title in a trust relationship for the people. Conveyance to a railroad of submerged land in Lake Michigan, where Grant Park is now located, was beyond the power of the state.[120] Control over mooring in yacht harbors as a service function by local government[121] and location of a filtration plan in a federally-improved harbor have been held valid.[122] The authority of cities in matters of navigable channels pertains principally to police powers, but in any event such powers depend upon the city charter and state statutes delegating authority. "Service powers" of municipalities, as distinguished from the traditional police powers, have been expanded in recent years.[123] Regulatory powers, both federal and state, have also been exercised

[111] *The Hine v. Trevor*, 71 U.S. (4 Wall.) 555 (1867).
[112] *Kelly v. Washington*, 302 U.S. 1, 58 Sup. Ct. 87 (1937).
[113] *Davis v. Department of Labor*, 317 U.S. 249, 63 Sup. Ct. 225 (1942).
[114] *The Hamilton*, 207 U.S. 398, 28 Sup. Ct. 133 (1907).
[115] *The City of Norwalk*, 55 Fed. 98 (D.C.N.Y. 1893).
[116] 244 U.S. 205, 35 Sup. Ct. 524 (1917).
[117] 348 U.S. 310, 75 Sup. Ct. 368 (1955).
[118] *City of Tacoma v. Taxpayers of Tacoma*, 78 Sup. Ct. 1209 (1958); *United States v. Appalachian Power Co.*, 311 U.S. 377, 61 Sup. Ct. 291 (1941).
[119] 30 STAT. 1151 (1899), 33 U.S.C.A. § 403 (1957).
[120] *Illinois Central R.R. v. Illinois*, 146 U.S. 387, 13 Sup. Ct. 110 (1892).
[121] *MacNeil v. Chicago Park Dist.*, 401 Ill. 556, 82 N.E.2d 452 (1948).
[122] *Bowes v. City of Chicago*, 3 Ill. 2d 175, 120 N.E.2d 15 (1954). The filtration plant concerned was the one located in Chicago Harbor north of Navy Pier.
[123] CHICAGO HOME RULE COMM'N, CHICAGO'S GOVERNMENT 22, 242 (1954).

more fully. One can say positively that no government has shrunk or receded in any sphere of activity during the past twenty-five years.

This trend may cause more and more frequent clashes between federal and state regulation. The power of Congress to exercise control over operations in interstate commerce is, of course, well established, but the problems arise where the federal government has only partially exercised its power. There are decisions holding that rather minimal regulation by the United States which conflicts with state regulation, either specifically or by implication, makes the state regulation inoperative.[124] We will certainly be called upon to deal with these questions again and again; to study the modern line of cases that trace back to *Gibbons v. Ogden*.[125]

Many service activities that are extremely important to shipowners and shippers alike are only partly maritime. The operation of highway bridges over navigable channels within the city limits of Chicago is in point. Keeping Chicago bridges closed at rush hours for needs of surface traffic was once a bone of contention in court[126] and out. For many years certain marine services and some measure of regulation have been provided by a harbor engineer and a harbor master in the City Department of Public Works. These marine activities were delegated to a Port Director in 1955, further responsibilities were added, and then in 1958 a new branch was established to deal with port matters. This will attend to city-owned dock and harbor facilities and will perform other duties as required by municipal ordinances. There are other municipal corporate bodies and governmental agencies that have been created under state legislation to perform specific services. With respect to marine matters, those which are of considerable importance include the Chicago Regional Port District,[127] the Sanitary District, and the Chicago Park District.

[124] *Cloverleaf Butter Co. v. Patterson*, 315 U.S. 148, 62 Sup. Ct. 491 (1942).

[125] 22 U.S. (9 Wheat.) 1 (1824).

[126] *Escanaba Co. v. Chicago*, 107 U.S. 678 (1883).

### Who Is at the Helm?

At times, the maritime client, domestic or foreign, will be completely frustrated in a maze of overlapping governments. He should be reminded at such times that our system of government is one of checks and balances, that too much power in one person or one bureau might be worse than what we have. But without inviting the danger of dictatorship, we should certainly try to eliminate some of the duplication, the overlapping of both regulatory and service departments of government. Now that we are becoming more international in all our Great Lakes ports there is added reason why we should seriously undertake such reforms.

[127] Mayer, The Port of Chicago and the St. Lawrence Seaway 186-213 (1957).

# Notice Requirements of the Miller Act

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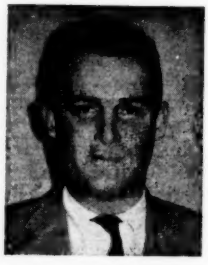
ONE problem which sometimes confronts a surety that has provided a payment bond pursuant to the so called Miller Act* for a contractor performing a United States government contract is the question of the statutory written notice of claim which must be provided to the prime contractor by a claimant who has not been paid by the subcontractor. For example, where a supplier of a subcontractor has not been paid by him, what notice must he give to the prime contractor in order that the provisions of the Miller Act will innure to the claimant's benefit? To state the problem in another manner, when does the surety have the defense available to him that improper notice was given to the contractor.

The act provides as follows on this point:

> ". . . . Provided, however, that any person having direct contractural relationship with a subcontractor but no contractual relationship express or implied with the contractor furnishing said payment bond shall have a right of action upon the said payment bond upon giving written notice to said contractor within ninety days from the date on which such person did or performed the last of the labor or furnished or supplied the last of the material for which such claim is made, stating with substantial accuracy, the amount claimed and the name of the party to whom the material was furnished or supplied or for whom the labor was done or performed. Such notice shall be served by mailing the same by registered mail, postage prepaid, in an envelope addressed to the contractor at any place he maintains an office or conducts his business, or his residence, or in any manner in which the United States marshal of the district in which the public improvement is situated is authorized by law to serve summons". Miller Act, 1935, 49 Stat 794, 40 U.S.C. Sec. 270b.

* 40 U.S.C. Sec. 270.



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At the outset, it should be pointed out that the scope of this article is limited to a discussion of those cases bearing on the sufficiency of the written notice required and the manner in which such notice is provided.

It would seem clear from a literal reading of the above provisions that the claimant connot invoke the remedial provisions of the Miller Act and bring suit under the payment bond, if he fails to comply with the notice giving requirements. Therefore, needless to say, it becomes important to determine what judicial interpretation has been applied to these requirements.

Perhaps the first requirement that should be discussed is the provision requiring that the written notice be sent by registered mail or by a summons issued by the United States marshal. It would now appear to be well settled that, whatever notice is provided, such notice need not be by registered mail or summons. In *Fleisher Engineering & Construction Co. v. United States for the use of C. S. Hollenbeck,* 311 U.S. 15 (1940), it was decided that where written notice was sent by ordinary mail and received by one of two contractors jointly performing the contract, such notice satisfied the Miller Act. The actual receipt of the notice and the sufficiency of its statements were not challenged. The Supreme Court in reaching its conclusion stated (at page 19):

> "We think that the purpose of this provision as to manner of service was to assure receipt of the notice, not to

make the described method mandatory so as to deny right of suit where the required written notice within the specified time had actually been given and received. In the face of such receipt, the reason for a particular mode of service fails. It is not reasonable to suppose that Congress intended to insist upon an idle form. Rather, we think that Congress intended to provide a method which would afford sufficient proof of service when receipt of the required notice was not shown."

This holding that the notice provided need not be by registered mail has been followed by the following cases in which this point has been specifically raised as an issue. *United States for the Use of Hopper Bros. Quarries v. Peerless Casualty Company,* 255 F2d 137 (8 Cir. 1958); *United States for the Use of Birmingham Slag Company v. Perry,* 115 F2d 724 (5 Cir. 1940); *United States for the Use of Franklin Paint Co., Inc. v. Kagin,* 129 F. Supp. 331 (Mass. 1955). However, there are numerous other cases in which no issue was made of the fact that regular mail or some means other than registered mail was used to notify the contractor.

Another issue which has usually been raised is the question whether or not the statutory provision for written notice is to be construed literally and strictly. In the *Fleisher* case, *supra,* there is some dictum to the effect that written notice is a condition precedent to the right to sue under the act. The court stated: (at pages 18, 19).

> "In giving the statute a reasonable construction in order to effect its remedial purpose, we think that a distinction should be drawn between the provision explicitly stating the condition precedent to the right to sue and the provision as to the manner of serving notice. The proviso, which defines the condition percedent to suit, states that the materialman or laborer shall have a right of action upon the said payment bond upon giving written notice to said contractor within ninety days from the date of final performance."

This language employing the phrase "condition precedent" has been relied upon by some lower court cases as a basis for the holding that in order to satisfy the Act the notice provided must be written. For example, in *United States for the Use of American Radiator & Standard Sanitary Corporation v. Northwestern Engineering Company,* 122 F.2d 600, (8 Cir. 1941) the question before the court was whether the requirement in the Miller Act for written notice to the prime contractor is a strict condition precedent to a right of action, or whether the giving of such written notice can be held to be waived by a verbal denial of liability on the part of the general contractor. The court held that the giving of written notice was a condition precedent to bringing an action under the act. The opinion expressly stated that the court believed the situation before it to be controlled by the language of the *Fleisher* case. In referring to the already quoted statement in the *Fleisher* case the court said (at page 602):

> "We are unable, from this language, to arrive at any other conclusions than that the giving of a written notice must be held to be mandatory, as a strict condition precedent to the existence of any right of action upon the payment bond. Since the right is purely a statutory grant, Congress necessarily could impose such creating conditions as it saw fit. While the statute uses the general term 'notice' its other language clearly shows that it is intended to be, in legal effect, the present action of a claim. That present action is required to be made in written form, stating with substantial accuracy the amount claimed and the name of the party to whom the material was furnished or supplied or for whom the labor was done or performed."

In attempting to overcome the contention that the notice of claim must be written, the plaintiff argued that the written invoices which were given to the subcontractor and employed by him to obtain progress payments from the prime contractor should be sufficient compliance with the statute. The court in answering the argument in the negative stated (at page 603):

> ". . . But the invoices were not presented to the contractor as the basis for a claim on the bond. They were furnished by plaintiff to the subcontractor as an ordinary commercial incident. When they were turned over by the latter to the general contractor, they were intended merely to indicate the material that had been furnished. They did

not purport to show what payments had been made to plaintiff, or what amount was owing from the subcontractor within ninety days after the last of the material had been supplied. They clearly did not constitute a written notice on the part of plaintiff to the general contractor, intended as the assertion of the claim upon the payment bond, and stating with substantial accuracy the amount claimed and the name of the party to whom the material was furnished. They could accordingly not be treated as a substitute for the written notice of claim which the statute imposed as a condition precedent to any right of action upon the bond."

The following cases are in accord with the *Northwestern Engineering Company* decision. *United States for the Use of J. A. Denie's Sons Co. v. Bass,* 111 F.2d 965, (6 Cir. 1940); *United States for the Use of Bruce Co., Inc. v. Fraser Construction Company,* 87 F. Supp. 1 (W.D. Ark. 1949); *United States for the Use of Westinghouse Electric Supply Company v. Robbins,* 125 F. Supp. 25 (D. Mass. 1954).

An interesting decision which would appear to reach a somewhat different conclusion from the *Northwestern Engineering Company* decision is *Coffee v. United States for the Use of Gordon,* 157 F.2d 968 (5 Cir. 1946). In this case no written notice was mailed to the general contractor. However, the claimant within the required ninety day period called upon one of the partners of the general contractor and advised him of the balance due the claimant from the subcontractor. At the same time the claimant handed the partner an itemized statement showing the various amounts due, and discussed these with him. The partner had full opportunity to examine the written statement having held it in his hands during the discussion. Judgment for the claimant was affirmed, the court holding that the written statement which the general contractor read and might have taken, constituted sufficient written notice under the Miller Act.

Another and more recent Fifth Circuit case apparently has extended the holding enunciated in the *Coffee* case, *supra. In Houston Fire & Casualty Insurance Co. v. United States for the Use of the Trane Co.* 217 F.2d 727 (5 Cir. 1954), it was held that the failure to give written notice of any kind did not preclude a recovery against the prime contractor under the Miller Act. Here the notice given to the general contractor consisted of a conversation held between the sales engineer for the claimant and office manager of the general contractor. In addition, there was a letter from the general contractor to the claimant in which the conversation was affirmed and the fact that the materialman had not been paid for equipment used on the government contract was acknowledged. The letter further indicated that payment to the claimant would be forthcoming within a few days.

The court in reaching its conclusion that written notice need not be supplied by the claimant to the general contractor relied in part on the *Coffee* case, *supra.* The court of appeals also seemed to add its own judicial qualification to the statutory language when it stated (at page 730):

> "It is not necessary that the writing relied on be signed by the supplier, it is sufficient that there exists a writing from which, in connection with oral testimony, it plainly appears that the nature and state of the indebtedness was brought home to the general contractor. When this appears the object of the statute, to assure that the contractor will have notice, is attained and the statute is sufficiently complied with."

It is difficult, if not impossible, to distinguish this case from the *Northwestern Engineering Co.* decision, *supra,* on any sound grounds. In both cases actual notice of the claim was received by the prime contractor but no written notice was provided. However, in the *Houston* case, there was a written acknowledgement of the conversation relating to the claim as opposed to a verbal denial of the claim in the *Northwestern* case.

It has already been noted that the *Houston* decision, *supra,* has accorded the phrase "written notice" a liberal construction in that it was held that there need not be a written notice of claim so long as there is some writing in existence that indicates notice was brought to the prime contractors attention. It would appear that at least one other case has grafted another qualification upon the statutory provision in question. *Steelcraft Manufacturing Co. v. Hewkin,* 148 F. Supp. 872 (E.D. Ill. 1956), is a case in which notice was not provided through the mails. Here one of

the claimants gave notice to the prime contractor through a division of the department of agriculture. The other claimant delivered a copy of his unpaid bill to the subcontractor who in turn at the claimant's request delivered it to the general contractor within the required ninety days. Both claimants were held to have given sufficient notice, the court citing both the *Fleisher* and *Houston* decisions, *supra,* as authority for the holding.

However, not all the decisions have been as liberal in their interpretation of the notice requirements as the *Steelcraft* case, *supra.* A recent case which would appear to apply a much more restrictive construction of the statute than the Steelcraft decision is *Bowden v. United States for the Use of E. J. Malloy,* 239 F.2d 572 (9 Cir. 1956). The claimant supplied earthmoving equipment to a subcontractor who had begun work in September, 1951, and who completed the work under the subcontract on October 31, 1953. Throughout the summer of 1952, the claimant made efforts to collect the delinquent payments and had numerous contacts with representatives of the prime contractor. On one occasion when the claimant threatened to withdraw his equipment from the job because of the delinquency in payments to him, agents for the prime contractor requested that the action not be taken, stating that the subcontractor had enough funds then due under its subcontract to enable it to pay all the bills incurred by it on the job in question which the prime contractor's agents then knew to be outstanding. The agents stated, also, that they did not propose to pay the subcontractor any money which they were not sure would be applied upon the subcontractor's indebtedness for work done under the subcontract.

In December, 1952, after completion of the subcontract, the prime contractor owed the subcontractor $17,000.00 in retentions under the subcontract. At a meeting held between the prime contractor's representatives and the subcontractor, it was arranged that creditors whose claims arose out of the job in question would be paid in full if their claims were less than a thousand dollars and would receive fifty percent of their bills if they were more than one thousand dollars. As a result of this meeting, the subcontractor, on December 12, 1952, wrote the prime contractor a letter listing the unpaid claims on the job in question. No letter was ever sent the prime contractor by the claimant.

The Ninth Circuit Court of Appeals held that the letter of December 12th sent from the subcontractor to the prime contractor did not constitute notice under the Miller Act. In so concluding the court stated (at page 577):

> "We think the teaching of the cases[9] which have dealt most soundly with questions regarding the sufficiency of notice when it is required to be given by Section 270 b(a) may be fairly summarized as follows: The giving of the written notice specified by the statute is a condition precedent to the right of a supplier to sue on the payment bond; the writing must be sent or presented to the prime contractor by or on the authority of the supplier; and the writing must inform the prime contractor, expressly or by implication, that the supplier is looking to the contractor for payment of the subcontractor's bill. Here there are plainly lacking some of the requisites of a notice sufficient under the rules just stated. There was, of course, no writing sent or presented by Malloy to the prime contractor. The letter from Hickey was certainly not sent or presented on Malloy's authority because Malloy did not even know of its existence until the trial. Finally, nothing in the letter would inform the prime contractor that Malloy expected it to pay Hickey's bill." (Footnote 9, citations omitted.)

A comparison of the *Bowden* decision with the *Steelcraft* case, *supra,* reveals the following. First, in each case actual notice of the claimant's unpaid bill was received by the prime contractor. Second, in each case some written notice was received by the prime contractor. However, in the *Steelcraft* case, the written notice was sent and authorized to be delivered to the prime contractor by the claimant although not sent directly to the general contractor. In the *Bowden* case the letter sent to the prime contractor by the subcontractor was not presumably authorized by the claimant because he had no knowledge that it was sent. It is this last factor that seems to have most influenced the court in the *Bowden* case and it appears to be the only distinguishing factor in these two cases. How

legitimate a distinguishing factor it is in view of the facts of the *Bowden* case is debatable. There is no question that the spirit of the Miller Act, if not its strictly construed provisions, was observed. However, there is also no question that the wording of the Miller Act, if strictly construed, gives support to the court's holding in the *Bowden* case.

A very recently decided case, which is in accord with the *Bowden* decision, *supra*, is *United States for the Use of J. A. Edwards & Company, Inc. v. Thompson Construction Corporation* 37 Labor Cases Par. 65,376 (S.D. N.Y. 1959). Here the written notice which the prime contractor received was a letter sent by the subcontractor to the prime contractor. No direct and formal notice was ever sent from the claimant to the general contractor.

The court held that this letter failed to satisfy the notice requirement of the Miller Act for the following reasons. First, the letter did not constitute notice because it was not sent to the prime contractor from the claimant or someone authorized by him to send it. Second, neither the letter nor the prime contractor's answer to it described the amount claimed with substantial accuracy.

To better understand this case it should be pointed out that the letter to the prime contractor indicated merely what the subcontractor believed to be the present balance owing the subcontractor by the prime contractor. In addition, it authorized the prime contractor to make any payments that remain due the subcontractor to the claimant. Therefore, in effect the letter constituted an assignment. However, the court felt that it could reasonably have been interpreted as an assignment for a separate and unrelated debt because the letter did not specify the assignment had been made as a result of the contract in question. Hence, the court's conclusion that the letter did not inform the prime contractor that the claimant was asserting a claim directly against the general contractor as required by the Act.

Another recent decision which rather strictly construes the notice provisions of Section 270 (b) is, *United States for the Use of the Noland Co., Inc. v. Skinner & Ruddock*, 164 F. Supp. 616 (E.D. S.C. 1958). Here it was held that the following letter sent to the prime contractor did not constitute sufficient notice under the Miller Act.

"November 2, 1953
Gentlemen:

In accordance with a request made by your Mr. Skinner, this is to advise that as of this date Williams Piping and Heating Company owes the Noland Company $3,128.11 on the officers Mess Job at Charleston Airbase which monies were due and payable in October. We feel sure that this customer will pay us as soon as sufficient collections are effected, and we are glad to work with you in any way for the mutual betterment of everyone concerned.

Very truly yours,
NOLAND COMPANY"

This letter which was received by the prime contractor was the only written notice of the indebtedness sent to the defendant. The court felt that this letter, although it indicated the amount of the indebtedness and identified the job in which it arose, did not constitute notice because it was not an assertion of a direct claim against the prime contractor. As support for this conclusion the court cited the following reasons. First, the language of the letter to the effect that, "We feel sure the customer will pay us as soon as sufficient collections are effected". Second, the fact that the letter was in reply to a request by the prime contractor for immediate notification of any payment delinquency of subcontractors on the defendant's jobs, whether under the Miller Act or not. Third, the fact the written notice was sent during the progress of the work rather than during the ninety-day period following completion of the work and that no further written statement of claim was sent by the claimant.

As opposed to these facts, however, there was evidence that four times following the sending of the letter the prime contractor assured the claimant that the subcontractor would pay the claimant upon receipt of payment by it from the defendant. This would tend to indicate that the prime contractor was aware of the fact that the claimant was not paid and was seeking payment from either the prime contractor or the subcontractor.

In all of the previous cases discussed, with one exception, the primary problems involved were the questions whether the notice should be written and whether it should be sent by registered mail. However, in one case in which written notice

was provided, the question involved was the sufficiency of the written notice. It will be recalled that in the *Skinner & Ruddock* case, *supra,* it was held that the written notice was insufficient because no claim was asserted directly against the prime contractor.

Another very recent case involving the sufficiency of the written notice and the elements that should be contained therein is *United States for the Use of Hopper Bros. Quarries v. Peerless Casualty Company,* 255 F.2d 137 (8 Cir. 1958). Here the following letter was sent by regular mail to the prime contractor by the claimant who had supplied rock to the subcontractor.

> "We Hopper Brothers furnished Omaha Rock Ex. Co., 60142 tons of rock in the months of May and June, for The Corps of Engineers, Omaha Levee Surfacing No. 1 Levee Project, with you Mr. Curphy the Prime Contractor.
> We are unable to collect for this rock, will you give us information as to why this bill is not paid?"

The above letter was in error as to the amount of the rock furnished which was 6,104.2 tons instead of 60142 tons. In addition, the letter failed to state the amount of money owed to the claimant by the prime contractor. The Eighth Circuit Court of Appeals reversed the district court and held the letter constituted sufficient notice under the Miller Act.

In order to understand the court's decision, a closer study of the facts involved is required. In reply to the claimant's letter of August 6, 1953, the prime contractor stated that it had discussed the matter with the subcontractor and the letter advised the claimant to discuss settlement with the subcontractor. Further the letter indicated that unless the matter was settled immediately by the subcontractor, it would be turned over to the subcontractor's bonding company by the prime contractor. There was evidence that subsequent to this the claimant had discussions with the agent for the subcontractor's bonding company and the subcontractor as a result of which agreement as to the amount owed and the deadline for payment was reached. However, the subcontractor never paid and after the ninety-day period had passed the claimant notified the prime contractor that no payment had been made and that he wished the bonding company to be notified.

The court in reaching its conclusion that the letter of August 6 was sufficient notice relied heavily on the fact that the prime contractor was in no way prejudiced by the claimant's failure to state in the letter the amount owed and to indicate correctly the amount of material supplied. It was also pointed out by the court that the defendant had paid the subcontractor without awaiting the expiration of the ninety-day period during which claims against the prime contractor may be filed. If the prime contractor had acknowledged and paid the debt it could have recouped in full from the subcontractor's bond. Instead, in its reply letter of August 8th, the general contractor indicated that the matter would be turned over to the bonding company for the subcontractor. In fact there was no bonding company for the subcontractor to which the matter could be turned over because the bond supplied by the subcontractor provided that it was for the sole benefit of the prime contractor. Thus it was only the prime contractor and its surety who were under any liability to the claimant in addition to the subcontractor. Therefore, the court felt that the general contractor had misled the claimant by this statement and had deterred him from amplifying the written notice which he initially had provided. In effect, the court is basing its conclusion in part upon an estoppel argument.

It is interesting to note that this case was decided by the same Eighth Circuit Court of Appeals which decided the *Northwestern Engineering Company* case, *supra.* Perhaps it is true that this case is distinguishable in some respects from the *Northwestern Engineering Company* case; however it does seem to represent a less literal and restrictive interpretation of the notice provisions as compared with the earlier decision.

Any summation of this discussion should provide some conclusions that may be gleaned from the cases reviewed. First, it is apparent that no clear cut trend appears in favor of a more liberal construction of the act as opposed to a restrictive interpretation of the notice provisions. It could be said that more of the later cases have shown a tendency to construe the notice requirements liberally and broadly than have not. However, there are so many exceptions to this statement among the latest cases where a literal and narrow interpretation has been accorded the notice provisions

in question, that it is impossible to state a general rule. In any particular case it would be necessary to refer to the decisions of the judicial circuit in question to study their effect. It appears that no uniform interpretation will apply until and when the United States Supreme Court has spoken on the various questions involved in providing notice.

However, reference to the cases does indicate that the following contention will be advanced against a surety in a case where no written notice or where insufficient written notice is provided and where the appropriate facts exist. This argument is that the Miller Act should be construed liberally and broadly in order to effect its remedial purposes. The fundamental purpose of the notice requirement is that the prime contractor be accorded notice of any claim against the subcontractor so that the prime contractor can refrain from making final payment to the subcontractor. Thus the general contractor will be subject to double liability. Therefore, proponents of the school of liberal interpretation argue that as long as the prime contractor receives actual notice, regardless of the manner in which notice is received, this is sufficient to satisfy the spirit of the Miller Act and permit recovery. Sometimes, in conjunction with this argument an estoppel argument is also presented where appropriate facts exists to justify it. Hence, it is the above arguments which are presented to and accepted by a court which rules in the claimant's favor.

On the other hand in those decisions which have denied recovery to a claimant because of no written notice or insufficient written notice the holding has been buttressed on a literal reading of the statute. The Miller Act states in essence that written notice asserting a claim must be provided stating with substantial accuracy the amount claimed and the name of the party to whom the material was furnished. These requirements are all a condition precedent to recovery under the Miller Act and are designed to prevent hardship to the prime contractor. Therefore, failure to comply with them precludes recovery.

Furthermore, in those decisions which have applied a strict construction to the act, the courts have sometimes provided the following policy argument as justification for such a literal interpretation. The Miller Act creates a right of action in favor of certain creditors of the subcontractor. This cause of action did not exist before and is the creature of the statute. The act provides certain terms which must be followed to create such a new cause of action. Therefore, the act should be construed strictly and all its terms complied with in order to permit recovery.

# Some Comments on Damages and the Genesis of "Jumbo Awards" in Negligence Cases*

G. I. WHITEHEAD, JR.
*New York, New York*

IT IS A great honor to be invited to address your annual meeting. It is also a great pleasure and privilege to be permitted to sit in on the deliberations at your work sessions and to share in your more relaxing affairs. I shall long remember the gracious hospitality of your member hosts, and the friendliness of all.

The subject I have been asked to develop is the matter of damages in the settlement and trial of negligence cases and the genesis of "jumbo awards" in the U.S.A. for bodily injury and death, a rather unhappy subject at best. It must be said at the outset that I propose to be blunt in handling the subject matter and consequently I am hopeful that when I have finished with these remarks, you will not think too harshly of me, a stranger in your midst who finds little comfort to be extracted from the claims-legal side of liability insurance in aviation. I have no wish to create a disturbance that is at all similar to the one produced by the uninvited guest at the lawn party, a common mammal of temperate North America capable of ejecting an offensive odorous secretion. That there is a rather offensive odor to the legal liability loss ratios in North America is not a secret and with your stakes direct and important certainly this is a serious challenge which might as well be recognized.

It would be presumptous of me to suppose that you will or should consider my private notions the final authority on damages stemming from legal liability claims and lawsuits growing out of aviation accidents in the U.S.A. It is a fact, however, that the Central Claims Office of the USAIG serves as a clearing house for a considerable volume of the aviation negligence claims and litigation in the United States. We make every effort to keep up with what is going on in our own business, and if there is any time left over, we also try to learn what others are doing. What I have to say to you today is the accumulated experience of many and in particular the experience of our own operation.

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While there are many factors in the trend upward in the amount of judge and jury awards in civil litigation to recover damages for bodily injuries and wrongful death in aviation accident cases, the principal causes, it seems to me, may be described as:

(a) Increased cost of living by reason of the reduced purchasing power of the dollar;

(b) Changing social and legal concepts in the field of recompense for bodily injury and death; and

(c) Broadening knowledge of the plaintiffs' trial bar in matters relating to the preparation and trial of aviation cases.

As common carriers by air take over the mass passenger transportation market from surface carriers, as they are doing, inevitably increased claim frequency follows and the airlines are now targets for the nuisance claims by passengers so common to railroads, buses and the like. Also, major airplane accidents are big business for the plaintiffs' trial bar and for the specialists who actively solicit the preparation of these cases from less experienced counsel retained by the injured passenger or the estates of deceased passengers.

There is an impression that death or injury in an aircraft accident brings a higher price in settlement or in a suit than

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similar injuries growing out of surface transportation accidents. This idea seems to prevail even when the injuries or damage are relatively unimportant as in the following paragraph taken from a complaint filed in a lawsuit to recover for lost baggage:

> "As the proximate result of the said negligence of the defendants in losing the aforesaid property the plaintiff sustained shock and injury to her nervous system and person, all of which said injury has caused and continued to cause plaintiff great mental, physical and nervous pain and suffering. Plaintiff is informed and believes, and thereon alleges that such injuries will result in some permanent damage to said plaintiff, all to her general damage in the sum of $50,000."

The plaintiff, a lady, was not married at the time which probably explains why there was no claim for loss of the right to conjugal fellowship.

Before launching into a discussion of the particular factors which occur to me to be responsible in a large measure for the sharp increase in the values attached to personal injury and death cases, it may be helpful to those of you who are not familiar with civil trials in the U.S.A. to say a few words about the judges and the jurors upon whom these factors operate. They are the people who have the responsibility to decide whether the defendant owes the plaintiff money damages, and if so, how much. Some common law countries have abandoned jury trials in civil litigation and others have severely restricted the conditions under which the parties can claim a right to trial by jury. In the United States either side to a civil lawsuit has the right to have the cause decided by a jury. One notable exception is under the Federal Tort Claims Act,[1] a statute which permits institution of civil suits against the United States government for damages. These cases are tried to a federal district judge sitting without a jury. It may be of interest to know that counsel for the successful plaintiff in these actions is limited in his charge for professional services to a maximum of 20% of the amount of the recovery.

Contingent fee contracts, that is, the fee stipulated to be paid to an attorney for his services in conducting a negligence action to recover for bodily injury only in case he wins it, and usually a percentage of the amount recovered after first deducting expenses, are proper when sanctioned by law and these contracts are the normal arrangement under which lawyers in the U.S.A. handle plaintiffs' negligence cases. Contingent fees, other than under the Federal Tort Claims Act, will vary generally between 25% and 50% of the amount awarded for the death or injury and, as to percentage, will depend sometimes upon whether the case is settled or tried. Champerty, where the attorney carries on the litigation at his own expense, which may include maintenance or financial assistance to the plaintiff, is not sanctioned but it is done by some in the competition to bring personal injury cases, particularly cases in which substantial recoveries can be expected, to their offices.

Similar to most human institutions, the quality of our judiciary will vary from the highest calibre of dedicated public servant to some who do not have the qualifications to serve. The same is true of jurors. In classifying judges and jurors in this manner, the standard is not, and never should be, the result for or against an insured defendant in any particular case. In the defense of lawsuits, all that insurers can ask, and have a right to expect, is fair treatment and justice, win or lose. Politics has a part, sometimes important and sometimes less significant, in the appointment or election of judges. This will change from jurisdiction to jurisdiction. In the main, our judges are devoted to their responsibilities, doing a difficult job fairly, honestly and with a high degree of intelligence. Also, many jury panels have intelligent, alert individuals who take this civic duty seriously and want to do what is right and just.

In the United States, there are state courts of original jurisdiction and federal district courts whose jurisdiction in aircraft accident litigation usually stems from diversity of citizenship, that is, the plaintiff and defendant are citizens of different states and the amount sued for is $10,000 or more. When major airplane accidents occur causing deaths and injuries in the numbers now being carried, the airline and its insurers are likely to be defending litigation in widely separated sections of the country. Having in mind the comments with respect to the varying quality of

[1] 28 United States Code, Sec. 2402.

judges and juries, plaintiffs' lawyers will often seek to file their actions in a forum which seems to them to have a climate for litigation most favorable to their client. As a plaintiff's lawyer, if the deceased passengers were motor car company executives, you would try to avoid a forum, such as Detroit, where it would be difficult not to have some on the jury with either direct or indirect labor union contacts and who might not be disposed to be overly generous to management people. Inasmuch as the airlines have on-line and off-line activities over a large area, the plaintiff's counsel has a wide choice of where he will commence his lawsuit. Defendants do not have the same choice, but there is maneuvering on the defense side, too, with respect to jurisdiction and venue. There are rules which permit transfer of a case in the interest of justice and in the discretion of the court from one federal district to another on grounds that it will be more convenient to the parties because of the place of the accident and the location and availability of witnesses and experts, to name a few commonly assigned reasons for transfer. This rule called "forum non conveniens" is not always uniformly applied. In two cases filed in New York in the same federal district for the deaths of two non-residents killed in an out-of-state accident, on the defendant's motion one was transferred to Wyoming, the state of accident, and the area within which most of those likely to be called as witnesses was located, as the most convenient place to try the lawsuit.[2] in a companion case another district judge refused to adopt his colleague's ruling and denied the motion to transfer.[3] The importance of this may be shown by the fact that the first case, the one transferred, was settled quickly on a satisfactory basis; the second case is still pending, the settlement demand in the "jumbo verdict" range, and it will probably have to be tried.[3a] Wyoming, one of our beautiful Rocky Mountain states, eighth in size in the country, has a total population of about 310,000, one-tenth that of Brooklyn, New York. Cheyenne, Wyoming, the city in which the transferred case would have been tried, has a population of about 40,000. The fact that New York counsel must personally go to Wyoming to try the case, pretty far West for an easterner, or lose control of it, and the probability that a jury in Wyoming would be more conservative in their ideas of value than would a jury in New York City, undoubtedly were persuasive reasons for settlement. Interestingly enough, two passenger death cases from the accident could not be settled and had to be tried in Cheyenne with resulting verdicts for amounts even higher than might be expected from jurors in densely populated east or west coast areas. A number of possible explanations were offered for what happened, but one I think you might find interesting. For years the defendant airline had its major maintenance and overhaul shops in Cheyenne, an operation which contributed substantially to the economy of the city. When the operation was moved to the West Coast the community lost an important source of income and although this was done some years ago, a feeling of antipathy toward the airline is said to linger on in some quarters.

In the airline accident involving multiple claimants, the defendant can never be sure in which jurisdiction the first case will be tried. Selection of the initial battleground depends pretty much upon the court in which the case first reaches the head of the trial calendar and is assigned to a trial judge. The trial in one jurisdiction is not determinative of liability in all the pending cases from the same accident, but the result of the first trial, both as to liability and damages, does exert an influence one way or the other on the open claims and to that extent the initial trial is important.

The twelve jurors who will hear and decide important and complicated fact questions relating to the proximate cause of the airplane accident and damages are selected from a panel of people who are typical of the citizens in the community. In the federal district court the area from which people are called to serve is usually somewhat larger geographically than the area from which state court juries are selected. These people are ordinary folks from all segments of society whose avia-

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[2] *McGarr, Executor, etc. v. United Air Lines,* 4 Avi 18,212 (USDC—S.D., N.Y., May 7, 1956).

[3] *Paul E. Merrill, Executor, etc. v. United Air Lines,* USDC—S.D., N.Y. (September 22, 1956).

[3a] Shortly after this address was given in Seville, the Merrill cases, husband and wife killed, were tried to a jury of 10 men and 2 women. They returned a verdict for the defendant United Air Lines after deliberating about 7 hours. Merrill was a Vice President of Sylvania Electric Company survived by two minor children.

tion experience, if any, is probably limited to a flight or two as passengers. Recently, one of our courts ran out of available jurors and, to replenish the panel, the judge directed the marshal, as permitted by statute, to go out on the square and bring people in off the street for jury service. Through an oral examination of the prospective jurors, called voir dire, which, depending upon the latitude allowed by the court, will vary in jurisdictions from brainwashing the jurors to a few simple questions asked by the judge; and challenges of jurors, each side is given peremptory challenges and is permitted to challenge for cause, the lawyers for each side attempt to have a jury comprised of people they hope will be most fair and just to their client's side of the controversy. This system of jury selection usually, (and it should), prevents either side from feeling completely happy about the jury as finally constituted.

A brief description of the jurors who served in the trial of two wrongful death actions recently decided, each action from the same accident but tried to different juries, one in a state court and the other in a federal district court, may be useful to give some idea of the sort of people we have on juries in tort actions. In the first case, the one tried in the state court, there were ten women jurors, six of whom were middle-aged housewives in modest financial circumstances, two employed as secretaries, one saleslady and a widow. The two men had modest jobs. This was a representative panel for the state court in the particular county. On the jury impanelled for the second case there were six women, five of whom were housewives of upper middle-class background, and one widow, a college graduate. The six men all had high school educations or better and reasonably rewarding employment. This was considered to be an above-average jury. On the issue of liability, both juries found against the defendant airline. The first jury was split 9 to 3. This number of jurors in agreement is sufficient for a verdict in some state court jurisdictions, as it was in that case, but in the federal district court, the verdict must be unanimous. If one juror does not agree with the other eleven, a hung jury results. On the issue of damages, the jury in the first case returned very substantial awards, a total of $320,000 for three deaths which the court reduced by approximately 25 per cent.[4] A judge is permitted to grant a new trial on the grounds that the damages awarded by the jury were either inadequate or excessive unless the parties accept the alternative, when an alternative is offered, of agreeing to ,pay or accept, whichever the case may be, the reduced or increased amounts set by the court. In the second case, the jury brought in verdicts in line with what the defendant had been willing to pay in settlement, but much less than the sums demanded by the plaintiffs.[5] It is not my idea in referring to the work of these juries or on the subject of juries in general to become engaged in the controversy between those who would eliminate jury trials in bodily injury cases and those who feel that the system of trial by jury should be preserved. There is one thought, however, that I might express, and that is, that insurers should carefully weigh the advisability of taking calculated risks on the results to be expected from judges and juries against the alternative of knuckling under to unconscionable demands. Although there were a number of factors involved in the trial of the second case referred to, all of which may have had some effect on the issue of damages, the fact is that the total demanded in settlement was approximately $2,000,000 the total offered was $400,000, and the total awarded by the jury was $450,000.

On the point of whether to have a jury trial or waive a jury in favor of a judge alone as the trier of issues of fact and law, if there is that opportunity, it can be frightening to think that the disposition of millions of dollars in a complicated fact situation, which is perhaps subject to honest disagreement among leading aeronautical experts, may be left to the decision of middle-aged housewives with minimum educational opportunities. Nevertheless, looking at the results in cases solely from the viewpoint of insurers, defendants have received far better treatment in many instances from jurors than they could ever expect from some judges. In the second case just mentioned, the trial judge has granted the plaintiffs' motion for a new trial on the ground that the damages

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[4]*Payton, Administrator, etc. v. Transworld Airlines, Inc. et al.*, and companion cases, Sup. Ct. Cal., City of L.A., January, 1959.

[5]*Anderson, Administrator, etc v. United Air Lines et al.*, and companion cases, U.S.D.C., S.D., Cal., Cen. Div., June 1959.

awarded by the jury were inadequate, saying that he was shocked by the meagerness of the verdicts. On the other hand, in the first case it was the judge who gave the defendants some relief from excessive awards by a jury. If either side in the trial of negligence cases had the opportunity to choose a judge or a jury of his preference, the trial of lawsuits would be quite enjoyable for him. Since most courts have more than one judge and some several, the assignment of trial judges is sometimes like the game of wheel of fortune. In a jury trial there is always a good chance with twelve citizens, especially in the federal district court where a unanimous jury is required for a verdict, that both sides in the course of a trial will have some jurors persuaded to their side or at least not unfriendly to their position.

Juries often are more emotional than judges in their reaction to the evidence as it is introduced. Most are affected to some degree by the personalities involved in the drama of the trial as it unfolds before them. Some small item in a case, perhaps wholly unrelated to the main thread of proof, may loom large in the minds of the jury when they begin their deliberations. Perjury, for illustration, seems to have a greater impression on juries than it has on judges. This is understandable. Judges hear so much perjury through the course of their years on the bench, that unless it is particularly flagrant or involves the point on which the case turns, they may ignore it in forming their judgment of the case. Juries, on the contrary, often become quite unhappy when someone is caught lying to them and do not hesitate to reflect this feeling in their decision.

A lady juror in the course of the jury's deliberations announced that she remembered reading in the newspapers many years ago that the deceased passenger had been sentenced to a federal penitentiary for an offense committed under the statute prohibiting the transportation in interstate commerce for immoral purposes of women and girls. Also, in the trial of a rather mysterious aircraft accident the airline was relying heavily on an "Act of God" defense, attempting to persuade the jury that there probably was structural failure in flight because of clear air turbulence of a most severe type. While deliberating on the issue of liability, one of the jurors happened to look out of the window just as a rising wind current was carrying some dry autumn leaves aloft in spiral fashion. He quickly pointed this out to the other jurors saying. "That is what the lawyer for the airline was talking about when he said that there can be sharp updrafts and downdrafts." In each of these cases the jury verdict was for the defendant airline, but there is no way of knowing to what extent the jurors were persuaded by the incidents described.

I use the word "drama" advisedly in describing negligence trials because skill in dramatic production, arranging stage effects with an eye to creating a striking effect for the jury, whether for the plaintiff or defendant, is an important ability for trial lawyers to have. I am speaking, of course, of legitimate trial tactics and techniques, and not of chicanery and tricks, such as planting stooges in the men's and women's washrooms, used also by the members of the jury, to talk about the fact that the defendant is covered with high limits of liability insurance, or the instance in which, during his opening to the jury, the plaintiff's attorney had the words "Lloyds of London" written conspicuously on a piece of paper clearly visible to the jurors to convey the thought of the proceeds of an insurance policy from which to pay the verdict. In those courts, and I emphasize that they are in the minority, in which judges either hold a loose rein on things or seem content to let trial counsel have as much latitude as they wish, the performance may take on some of the color of a circus or burlesque. Judge baiting, treading on the fringe of a contempt of court citation, as they test how much nonsense the judge will put up with, is a studied technique used effectively by some trial lawyers when they are permitted to get away with it. Conduct which may bring only a slap on the wrist in some jurisdictions, in other places may be treated as a serious offense deserving prompt and effective punishment. Plaintiff's counsel in the course of a long trail took a lady juror out for an evening of dinner and entertainment. When this was brought to the attention of the trial judge, and upon assurances of the lawyer that he did not discuss the lawsuit with the juror, the judge permitted the trial to continue with the remark that in the future counsel's behaviour should be more circumspect. In another case in a different jurisdiction the trial judge considered similar conduct a

serious breach of ethical standards, declared a mistrial and censured the lawyer severely.

Many judges are more generous than juries in assessing damages and in the ideas of value they express at settlement conferences in chambers prior to trial. It may be interesting to recount how one judge, sitting as the trier of fact and law, measured damages against the United States government in a suit growing out of the death of a civilian passenger in a crash of a United States Air Force aircraft.[6] The decedent had a joint life expectancy with his wife of thirty years. His average earnings were in the $25,000 per year area, out of which the judge found he contributed approximately $10,800 per year to his family. With these figures determined, the court treated the computations to find the present value of the lost contributions from the deceased to his family as simply an exercise in arithmetic and held this figure to be $202,110. There were two minor children surviving and therefore the additional question to be decided was the dollar value of the loss to them of parental care and guidance. This figure cannot be determined by formula and must be based upon testimony with respect to the sort of father the deceased was to his children. The judge awarded $20,000 per child for the deprivation of parental care and guidance. The total recovery allowed was $242,110 and an additional amount for funeral and burial expense. If this case had been tried to a jury, it is not unreasonable to speculate that the recovery might have been less. Another recent case decided by a federal district judge sitting on the admiralty side of the court, without a jury, involved the death of a 51 year old lawyer survived by a wife and no children.[7] The trial court awarded $250,000 plus interest at 6% from the date of death even though the statute giving the cause of action makes no specific reference to interest on the judgment. The lawyer's gross income from his law partnership was in the range of $42,000 per year but there was persuasive evidence introduced by the defendant airline that the widow's loss from contributions received from her husband did not exceed $7,300 per year. A jury hearing the evidence on damages might well have been less generous. In a case just decided against the government for wrongful death under the Alaska wrongful death statutes which limit recovery to $50,000, the judge awarded the full amount.[8] The following quoted from the opinion illustrates this arithmetical approach to damages used by some federal district judges:

> "There is no serious dispute that if plaintiff-administrator is entitled to recover at all, he is entitled to recover $50,000 the maximum allowable under Alaska law. With decedent's life expectancy at the time of the trial being 30.29 years and his earnings at or around the time of his death being at least $582 per month, the actual damages suffered are well in excess of $50,000."

The decedent was a civilian employee of the United States Air Force, survived by a wife, who remarried less than a year after her husband's death, and no other dependents.

These remarks with respect to judges and juries will perhaps serve to emphasize how necessary it is to be in close touch with things on the local level such as, knowledge of the judges, court house politics, type of people on the panel, verdict trends at the current session of the court, and perhaps things so intimate as whether the trial judge's ulcer has been quiescent in recent weeks. Indigestion, too, has a hand in shaping the law.

Even when language is not a barrier and the exchange of correspondence is between lawyers in countries having a union of interests and daily commercial and social exchange, such as exists between the United States and Canada, it is impossible for claims and legal people of one country to keep currently informed of the peculiarities of a particular locality in the other country, peculiarities which may have an important effect on the outcome of civil litigation. It is not possible, either, for lawyers in Canada and the United States to always understand the meaning and in-

[6] *Rogow, Executrix, etc. v. United States of America*, 6 Avi 17,474 (U.S.D.C., S.D., N.Y., May 25, 1959).

[7] *Stiles v. National Airlines, Inc.*, 161 F. Supp. 125; aff'd. 268 F 2d 400.

[8] *Vigderman, Administrator etc. v. United States of America* 6 Avi 17,600 (U.S.D.C.—E.D., Penna. July, 1959). See also *O'Connor, Administratrix, etc. v. United States of America*, U.S.C.A., 2 Cir., August, 1959 affirming a judgment of the District Court ($150,000 award) provided the appellee files a remittitur in the amount of $60,000.

tent of tenuous, and even not so subtle, variations in the substantive law and rules of practice and procedure of the other's country. One illustration is the multiple death claims from an accident in British Columbia which were disposed of without loss payment on the basis of a delicate veriation in the law finally, decided in the Supreme Court of Canada.[9] Directly following the accident, and for several months thereafter, the aircraft liability insurers in the United States were pressing offers to settle with the heirs and with those in charge of the subrogation rights vested in the "state fund" from which workmen's compensation benefits were being paid. It was only after the Provincial Workmen's Compensation Board refused to negotiate and insisted upon settlement for the full amount of the capitalized reserve for each case that the tenuous legal route was discovered under the Families' Compensation Act which ultimately led to the decision of the Supreme Court of Canada holding that no right of action existed. Canadian counsel, I am sure, can relate having encountered similar difficulties in United States law.

An already controversial business may be made even more contentious when language differences exist. Translations, although technically accurate, often will not impart the meaning intended and the person relying upon a translation will be entirely wrong if he thinks that the expressions and phrases when turned into his language will always reflect the meaning intended by the writer. Most of the difficulties that we have experienced in looking after claim matters in other countries stem from different philosophies with respect to when to pay and how much, that is, questions of legal liability and the measure of damages. A frequent area of dispute is the limitation of liability provided in the Warsaw Convention.[10] In the United States the 125,000 gold francs for bodily injury is construed to be a limitation not an indemnity, and it is therefore up to the claimant to justify damages within the limit. I think that this construction is commonly accepted. However, it has been the subject of hot dispute in some countries when insurers have declined to pay all death claims, whether infant children, housewives, or the head of a household, should receive the full 125,000 gold francs. Such controversies can have serious consequences. Governments become involved, reprisals are threatened, there is much unhappiness, and quite often the difficulty has its origin in a mistake of meaning or the misinterpretation of some simple statement of policy. Perhaps you have experienced the same problems in correspondence with your claims and legal representatives in the U.S.A.

I hope that these comments may be a useful contribution to enlightenment in your quest for knowledge of the handling and disposition of claims-legal matters in my country, but some of the elements which produce large settlements and verdicts in bodily injury and death cases are present everywhere and well known to all.

It was near the time for the baby to be born and the happy couple felt that they could no longer put off telling their five-year-old son that soon there would be a new baby in the house.

"You know, there has been a stork flying over our house," the father said to the boy "and he seems to be swooping close to the roof."

"You had better not say anything about this to mother" the boy answered. "It might scare her and she is pregnant, you know."

Perhaps what I have to say next is as well known to you as the observable fact of pregnancy was to the precocious boy. There is not much new that can be said about cycles of inflation which raise the cost of living. Twelve years or so ago, three death claims growing out of an airline crash had to be defended against a leading member of the trial bar specializing in plaintiffs' negligence cases. It was a long and bitterly contested trial to its happy ending for the defense when the jury came in with a verdict in favor of the defendant airline. Defense counsel and the client, as you might expect, found the result quite gratifying. While the fees of attorneys for the defense are not contingent upon the outcome of the trial, it is impossible to escape the fact that the cost of professional services do reflect success, particularly if a considerable sum was at stake. In this case the bill was for $10,000, a substantial charge at that time, considered unconscionable in some quarters and the subject of considerable controversy and exchange of correspondence before it was accepted. Twelve years later, another airline

[9] *Cairney v. MacQueen*, 4 Avi 18,126 (Supreme Ct. of Canada, May 24, 1956).

[10] Article 22

had to be defended in three death cases, a trial of which also extended over a long and hard fought period with an unhappy ending for the defense when the jury came in with a verdict for the plaintiffs. The attorney's statement for professional services in the defense of this litigation was for $46,000. This charge was accepted and paid after an exchange of letters to clarify certain misunderstandings. The important problem of increasing costs to defend negligence cases is not within the scope of these remarks. It is just that the comparison seems to be a useful example of the extent to which inflation jacks up the prices of everything we buy, including the price of legal services.

Courts in the U.S.A. generally instruct juries that in determining the amount to be awarded in wrongful death cases, they may consider the reduced purchasing power of the dollar.[11] Most statutes which give a cause of action for wrongful death provide for damages stemming from the pecuniary loss to certain next of kin who survive. When the head of a household is killed leaving a dependent wife and minor children, it is the class of case in which inflation is most often considered in determining how much to award to the family. The increase in the number of dollars necessary to support the widow and to raise and educate the children is not a mystery to the average juror who faces a similar problem himself each day. The widow may properly claim the right to support through her life expectancy reduced at reasonable interest to its present value. The children are entitled to look to their father for care and guidance, at least until they are emancipated.

For a number of years we have had good business conditions in the United States. There has been substantially full employment which means money to spend for goods and services. We have seen a broadening of services and welfare provided by the government in the form of old age benefits, unemployment insurance, sickness and disability insurance, and general relief benefits frequently administered in a manner which encourages idleness and malingering, and which have undoubtedly brought about a feeling on the part of many that the world owes them a living. Higher budgets to provide and pay for these services from the school district level to the federal budget are commonplace. In Washington for a number of years the folks in government have been using figures so large that they cannot be imagined. There are popular giveaway programs on television and radio. Quiz contests have involved prizes of many thousands of dollars to the winners. It is little wonder at the birth of the "jumbo verdict" in this atmosphere of easy money and something-for-nothing, encouraged by genuine feelings of sympathy for people who have sustained a grievous loss through the instrumentality of a financially responsible corporate defendant or an insured individual, and perhaps in circumstances which cause the jury to consider the size of the verdict as a means to punish the wrongdoer. Society which produces the "jumbo verdict" does not express any great desire to pay out of its own pocket for this concept of damages. The same juror who chastises the railroad or public utility with a big verdict in a negligence case is among the loudest to complain at the first sign of a fare or rate increase to meet costs of operation and return a profit to the owners. The same is true when a proposal is made to increase automobile liability insurance rates. There is a delusion that the money to pay for these social concepts comes free-flowing from some vague entity with no pause to think that revenue must have some more definite source and that the source is ultimately the public. Even the organized plaintiffs' trial bar, of which I will say more later, does not think that liability insurance rates should be increased to establish funds from which to meet the impact of verdicts and the increasing costs of handling claims and litigation. In an official publication of this organization it is reported:

> "Your Board of Governors met all day on Saturday, April 12, in Washington, D. C., and, among numerous other projects, consulted with insurance actuaries, with a view to initiating a statistical study ascertaining the true facts concerning the impact of jury awards on liability insurance rates. We hope to have the findings of this study available by convention time in August, and believe that it will give the lie to insurance company misrepresentations as to the effect of jury verdicts on automobile insurance rates."

[11] "Damages should be increased in proportion to the decreased purchasing power of the dollar" 25 C.J.S. 1242.

This brings us to the next point, the changing social and legal concepts in the field of recompense for bodily injury and death which may be more conveniently handled in two parts: (a) social concepts as determined by the collective conscience of the community; and (b) new theories of responsibility as shaped in the minds of lawyers and urged in the halls of the legislatures and in the courts.

The so-called collective conscience of the community is an intelligent sounding expression used more by sociologists, but in the personal injury field, to put it bluntly, most often it is nothing more than a feeling of obligation to do right or to do good with someone else's money, the "Robin Hood" concept of justice. All of those who have the day-to-day problems of attending to negligence cases for defendants and plaintiffs do not share the same enthusiasm for humanitarian movements in the law of torts, although the reasons may be different. The trial bar wishes to preserve the jury system. Students of society, at least in automobile accident cases, are seeking some substitute for the courts which would eliminate issues of liability and establish a schedule of indemnities. There are others who would apply principles of absolute liability when accidents occur in the manufacturing and products field on the theory that society must look after and pay for the misfortune of victims of accidents, the manufacturers to pass the costs along to the public in the price of their products. Absolute liability concepts usually carry with them limitations on liability and administrative disposition of controversies, such as we have in the administration of workmen's compensation laws. Through the trial of law suits, adversary proceedings, counsel for the defense and for the plaintiff earn their living. Consequently, it is not reasonable to suppose that they can be expected to urge a program that will eliminate lawsuits and destroy them professionally. Nevertheless, it would be unfair to the trial bar to conclude that they are motivated only by personal interests, in particular the size of recoveries and contingent fee contract. Many lawyers who oppose the humanitarian movement express the view that the ideas of common law liability recognize the dignity of the individual and his basic rights. They find in the liability without fault concept with the loss distributed among the public, something of the same idea as expressed in the Socialist theory: "To everyone according to his needs; from everyone according to his means."

This does not imply that plaintiffs' counsel are not interested in opening new vistas in tort liability or in removing obstacles to recovery for their clients. At the regular sessions of Congress and of the state legislatures, a number of bills are introduced which relate to new theories of legal liability and compensation in bodily injury and death cases and matters of practice and procedure in the trial of these cases.

Each year bills are introduced in the legislatures of those states which have a limitation on the amount of the damages recoverable in an action for wrongful death, proposed legislation which would either eliminate or substantially increase the limitation.

Many of the people serving in the Congress and in state legislatures are attorneys engaged in the practice of law. When in the course of handling a negligence case, some rule or technicality stands in the way of recovery for the client, it is not uncommon for the attorney-legislator to introduce a bill to remove the obstruction and clear the way for the future. The attorney who was representing a passenger injured in a major accident was astonished to learn that he was prevented by federal law, an act of the Congress, from using a Civil Aeronautics Board Accident Investigation Report in the trial of a civil action growing out of the subject matter of the report.[12] His bill in the state legislature to frustrate this federal law, of course, did not get far.

While not directly related to the subject of damages, this perhaps is a good place to touch briefly on the work of the Civil Aeronautics Board when major aircraft accidents occur. Under the Federal Aviation Act of 1958 the Civil Aeronautics Board retains responsibility for the investigation and analysis of aircraft accidents. Considerable emphasis is placed by plaintiffs and defendants on the accident investigation hearings and the formal report of the board's findings and conclusions. According to the board's rules, the hearings and reports are concerned with safety in the future—there are no adverse interests or adverse parties. The separate opinion, concurring and dissenting, of

[12]Federal Aviation Act of 1958—Sec. 701 (e).

board member Hector in a recent accident investigation report[13] contains an important and interesting restatement of what the board's position should be with respect to matters of legal liability stemming from aircraft accidents:

> "I therefore think that the Board should confine itself to an accurate description of the sequence of events and a statement of the mistake in judgment which was responsible for the accident, leaving such matters as responsibility and liability to the pilot certificate procedures of the FAA, and to the courts if the issue of liability is raised therein.
>
> "The Board has always attempted to keep matters of liability and responsibility out of its accident investigations. The success of these investigations depends upon the cooperation of all parties, and their being kept non-adversary in character. While the mere recital of the factual chain of events and the factual cause of an accident may carry grave implications of responsibility or liability, the Board has always endeavored so far as possible to keep legal conclusions out of its accident reports."

I am not unmindful that a recitation of technical legal rules of interest mainly to lawyers can be a tedious thing for an audience to endure, especially an audience of people such as yourselves who are charged with administrative and executive work at the top level of underwriting aviation risks, and it is not my wish to weary you with an extended treatment of legal principles. Nevertheless, as an essential part of the whole picture, and at the risk of being dull, it seems necessary to touch upon some rules of law which have, or will have, an important part in shaping legal liability loss ratios in the U.S.A.

The comparative negligence rule is probably well known to those of you from civil law countries. We have comparative negligence in only a few of our states and in some federal statutes such as the Federal Employers Liability Act.[14] Under this rule, to put it briefly, the jury determines the percentage that the plaintiff's fault contributed to the accident and reduces the damages in that amount. The common law defense of contributory negligence in effect in the majority of our states has long been an object of intense dislike by those engaged in the trial of negligence cases for the plaintiff. Bills are introduced in many state legislatures to abolish the rule that the plaintiff whose negligence was a proximate cause of his injury cannot recover by substituting a rule of comparative negligence or some other device for apportionment of damages. Many of those sponsoring this legislation are the same people who want to preserve the jury system, have recovery without limitation on the amount of damages, and also have the odds on a plaintiff's verdict fixed in advance in their favor, what card players refer to as a "stacked deck". What these lawyers lose sight of when they join forces with students of the humanitarian movement to amend common law principles and argue in favor of a rule which permits recovery by a party guilty of contributory negligence, is that there is a strong possibility they are being led down the garden path toward liability without fault, severe restrictions on jury trials, and ceilings on the damages that may be awarded, the very things they want the least.

Conflicts of law questions, whether to apply the law of the place of wrong, lex loci delecti, or the law of the place of the trial, lex fori, create a number of interesting problems in the field of changing legal concepts. One of importance is the application of the doctrine of res ipsa loquitur in airline passenger cases. Briefly stated, this doctrine creates an inference from which the jury can find that the accident resulted from the defendant's negligence. It is a rule of evidence, and the rule itself is an old one, that some courts have extended to aviation. Its application usually depends upon facts which establish that: (a) the airplane was in the defendant's exclusive control; (b) airplanes ordinarily do not have accidents unless there is negligence; (c) the defendant has superior knowledge of the facts and circumstances of the accident; and (d) the plaintiff was free from contributory negligence. In the conflicts of law field, the question arises whether the doctrine creates a substantive right or is simply a procedural matter. In a trial in the state where the accident occurred, if the res ipsa loquitur rule does not apply to, say, an airplane accident or to collision cases, to succeed the plaintiff must allege and prove specific negligence. If the state in which the case

[13] CAB—Aircraft Accident Report, File No. 1-0061, released July 6, 1959.
[14] 45 U.S.C. 51-59.

is being tried applies the rule as simply one of procedure both to aircraft accidents and collisions, the plaintiff will have the benefit of the inference of negligence. In a case in point, the trial judge refused to follow what he termed the medieval law against the application of res ipsa loquitur of the state where the airplane accident occurred and instructed the jury that they were allowed to consider an inference of negligence from the happening of the accident. While the application of res ipsa loquitur does not require a verdict for the plaintiff, and experience shows that defendants have won a number of cases in which it was applied, the court's instruction on res ipsa loquitur, depending upon how it is given, can invite a verdict for the plaintiff in a case in which the plaintiff has been unable to produce affirmative evidence of negligence sufficient to raise an issue of fact for the jury. The doctrine has been extended in one state to shift the burden to the defendant to prove a non-negligent cause for the accaccident.[15] In the case of an airplane which disappears without a trace or means of reconstructing what occurred, this extension of the res ipsa loquitur rule virtually imposes liability without proof of fault.

The United States rule on conflicts of law questions is that the law of the place where the accident occurred or "force impinged", governs the rights of the parties in fixing the liability of the wrongdoer. That this concept is not accepted in all countries was the basis for a novel approach to a possible means of circumventing a state statute limiting damages for wrongful death. The accident occurred in the U.S.A., Nantucket, Massachusetts, a state which limits recovery to $15,000. The deceased passenger was a U.S.A. citizen and the airline a U.S.A. corporation with an on-line station in the Province of Quebec, Canada. It was argued in support of a demand for settlement substantially in excess of $15,000, that the Canadian courts would take jurisdiction in an action filed against the airline there and apply the Quebec law, the lex fori, which has no statutory limitation on damages for wrongful death. This very interesting theory was not pressed, but if pressed in the future, the issue will have to be disposed of ultimately by the Supreme Court of Canada.

[15] *Weiss v. Axler* 328 P. 2d 88.

There have been a series of efforts to avoid the $15,000 limitation on wrongful death applicable to this accident including an attempt to establish the law of Massachusetts as it existed, or so plaintiffs allege, in colonial days. The most recent effort was to state a cause of action for breach of the contract of carriage which was entered into in New York where the ticket was purchased.[16] The judge granted the defendant airline's motion to dismiss the causes of action in contract saying, among other things:

> "Where an allegedly wrongful death results from an airplane accident, the action is governed by the law of the place where the tort was committed, notwithstanding allegations in the complaint of a breach of contract by the defendant. Although the complaint, as here, is couched in traditional contract phraseology, the liability is predicated on proof of negligence constituting breach of a duty owing by the defendant to the decedent.
>
> "The fact that the airplane ticket was purchased in New York does not make the New York law of contracts applicable. The controlling law is that of Massachusetts, the place where the accident occurred."

The Federal Employers Liability Act[17] is a statute which gives a cause of action to injured employees against interstate railroad carriers. In recent years bills have been introduced in the Congress to extend this law to air crews. The bill would provide that a rebuttable presumption shall exist that the injury or death of the air crewman resulted from the negligence of an officer, agent or employee of the airline or by reason of a defect or insufficiency due to negligence in its equipment. In the disappearance case under circumstances which cannot be investigated, as mentioned in connection with res ipsa loquitur, the practical effect of the proposed law is to impose liability without fault.

There are cases now pending, and being followed with great interest, in which the estates of deceased air crew members have

[16] *Schwarm et al., v. Northeast Airlines,* 6 Avi 18,-212 (U.S.D.C., S.D., N.Y. June 30, 1959); aff'd U. S.C.A., 2 Cir.

[17] For bill in Congress, see H.R. 1044 (Zelenko) 85th Congress 1st Session.

filed suit against the airline to recover damages under the provisions of the Federal Death on the High Seas Act.[18] This is an effort to circumvent the limited recovery allowed under state workmen's compensation laws. The defense is predicated upon the argument that workmen's compensation benefits are the exclusive remedy for injury to air crew members growing out of and in the course of their employment.

The moral for liability insurers to draw from these brief comments on some legal concepts obviously must be that, to be realistic, they are compelled to regard professionals on the plaintiffs' side of negligence cases as tireless rivals who do not rest and who are ready to pounce on every weakness in the defense of these cases. When no weakness is to be found, or no cause of action exists, they seek relief from the Congress and in the state legislatures. Some judges, too, are sympathetic to persuasion that there must be theories of liability and procedural steps that will weigh the scales in favor of the unfortunate victim of the accident.

From the early barnstorming days of aviation, stunt flying, wing walking and passenger hops at country fairs, and the like, flight in an airplane has been surrounded with an aura of adventure. It is surprising to learn how many adult people even today have yet to make their first flight. There are some who still feel that anyone who flies takes his chances whether he gets back on the ground again in one piece. When these people are called for civil jury service, and picked to serve on an airplane accident case jury, the defense of assumption of the risk of perils of the air may be effective with some of them. Nevertheless, in airline accident litigation involving common carrier obligations to farepaying passengers the assumption of risk defense has lost much of its effectiveness as the state of the art has advanced and for the reasons assigned by one judge in granting a plaintiff's motion to strike it as an affirmative defense interposed by the defendant airline:[19]

> "Does a passenger entering upon the modern commercial plane voluntarily assent to a known danger either with respect to the plane itself or its operation?
>
> I think not. The airplane, like the automobile and the railroad, has come to stay. The experimental days of the airplane with the dangers incidental to any system of trial and error are long passed and the airplane as a mode of travel holds out to the fare-paying passenger the same assurance of proper conveyance as the railroad, the steamship or the bus. The Court takes judicial notice of the extensive advertising campaigns by various airline companies subtly emphasizing the safty of travel on their lines. At this date there is as little justification for upholding this defense as there would be in the case of other accepted means of conveyance."

In the years before World War II, it was a rare event to find a person with the qualifications of a competent lawyer specializing in negligence work who was also either an aviator or on speaking terms with matters relating to the business of aviation. One volume of the Commerce Clearing House Aviation Law Reports contains all the significant aeronautical law cases in the United States from 1822, the early balloon cases, to 1945. The decisions reported between 1945 and 1958 require five volumes. This increase in litigation of matters having an aviation flavor following World War II is, in itself, a measure of the increased tempo in all classes of flying from student instructions to the expanding operations of the major airlines.

The Air Force of World War II trained thousands of air crewmen as well as thousands of ground crew specialists. Some of these men had completed their legal training before the war; others upon separation from the service took advantage of a government-financed education and obtained their law degree in the years immediately following the war. Today it is not unusual to find lawyers with some knowledge of aviation and many whose knowledge is considerable and the same applies to underwriters. Some are in the insurance industry as specialists in the aviation insurance field. Some have gone into the general practice of law, either on their own or with law firms. Still others have become specialists on the plaintiffs' side of airplane negligence cases.

It is not intended to suggest that a lawyer must also be an aviator to try an airplane case. The bulk of the serious cases

[18] *King, Administrator, etc. v. Pan American World Airways, Inc.* 166 F. Supp. 136; aff'd 6 Avi 17,666 (9 Cir., August 27, 1959).

[19] *Lopez et al., v. Resort Airlines, Inc. et al.*, 18 F. R.D. 37 (D.C., N.Y.).

are being handled on the plaintiffs' side by trial counsel who have been successful for a number of years in the trial of all sorts of negligence cases. What I do mean to convey is the idea that out of World War II a number of trained aviation people went into the legal profession and these young men were available to assist in preparation and to take some of the mystery out of aviation for senior trial counsel in their invasion of what to them at the time was a novel field of law and fact. Since these early sorties into aviation negligence trials, passenger death and serious injury cases from major accidents have become important business for the leading members of the trial bar.

The plaintiffs' lawyers in the U.S.A. are well organized, hold annual meetings, arrange frequent regional meetings and publish legal literature and a law journal. They operate as, and are, a bar association. Certainly no one has any quarrel with the idea of an organized bar of plaintiffs' trial lawyers. The insurance industry's counsel has had similar organizations for a number of years. At meetings and in legal literature, specialists in the aviation field, as well as in other fields of tort law, discuss their techniques of preparation and trial, warn of pitfalls to be avoided and describe successes. It is not a secret that through these contacts the specialists obtain referral business from other lawyers. Lawyers cannot advertise, but there is no prohibition against them holding their lightning rods high, writing books and giving lectures. One plaintiffs' negligence firm has built and occupies a five story modernistic building each floor dedicated to some public utility, railroad or airline whose funds, contributed through personal injury verdicts, provided the money with which to erect the firm's new offices. It is the talk of the town. The number of speeches, panel discussions, legal literature and the like, on the subject of aviation, and in particular aviation negligence cases, is increasing all of the time. The substance of what I am saying is that the advantage to the defense, if there ever was any, from want of knowledge about technical things necessary in the perparation of the plaintiff's aviation case, has largely disappeared.

In 1938 the Federal Rules of Civil Procedure[20] were adopted and since then a number of our states have passed similar rules for their courts. The high purpose of these rules is to simplify procedure, reduce technicalities, and to decide cases on their merits efficiently and rapidly. Some defense counsel say that they like the rules because they provide a means for ferreting out fraud, lying and exaggerated claims. Looking at discovery--depositions, interrogatories, admissions, inspection of records and documents--solely as people concerned with defending against death and serious injury claims which stem from major airplane accidents, as a practical matter all the defendant can accomplish with discovery in most cases is to examine on the issue of damages and he probably already knows most of that bad news. Discovery, the means provided by law for obtaining disclosure before trial of all facts and documents related to the accident, in the cases we are considering is an effective tool in the main, only for the use of plaintiffs. The technique advocated by the plaintiffs' trial bar as the best means to extract the top value from the case is to "rock 'em and roll 'em". Translated into English this means to tire the defendant with repeated and exhausting efforts. There is no weapon in the plaintiff's arsenal that is a better means to that end than the discovery provisions of the Federal Rules of Civil Procedure. The rules fall short, in our experiece, of accomplishing the high purpose of simplification and efficient and rapid disposition of litigation. The contrary is probably more often true.

It was not the intent of the drafters of the rules that they should be used as a weapon of harassment. It is true that the defendant can petition the court for relief when it appears that the rules are being misused. This is not an altogether satisfactory answer in the defense of multiple lawsuits from the same accident in widely separated jurisdictions. To illustrate, the plaintiffs in a number of cases joined forces and employed a specialist to assist in the preparation of the lawsuits for trial. These specialists usually insist upon a contingent fee plus their expenses and a per diem if they are retained to assist through the trial. Eight hundred interrogatories, more or less, were prepared and served in all of the cases, lawsuits pending in courts from the east coast to the west coast of the United States. These questions covered in exhaustless detail trifles as well

[20] 28 U.S.C.

as important particulars of the accident; material as well as patently immaterial matters and called for anwers in the vein of the answers required to the question, "Have you stopped sleeping with that woman I saw you with?" "Answer yes or no!" A limited answer "yes" or "no" implies illicit cohabitation. The possible answer, "No, she is my wife," changes the whole mental image of the relationship. Objections were interposed to the interrogatories and argued in all cases. The several federal district court judges hearing argument on the defendants' objections ruled differently and their differences were considerable, ranging from an arbitrary position that all eight hundred should be answered to a ruling that the defendants' objections to a large number of the interrogatories were well taken and no answers would be required in those. You perhaps have some appreciation of the work involved in collecting the information and drafting answers to eight hundred questions. We will see more of this technique, particularly if the courts encourage it by arbitrarily compelling the defendant airlines to answer most of the questions.

The court has power to control the taking of depositions by eliminating areas of inquiry and by ordering that they must be completed within a specified length of time. The court has power to terminate depositions. Experience in attempting to control this phase of discovery has been mixed, too. Since your insureds are engaged in a fast means of moving people from place to place, some judges feel it is no problem to take key airline people from their jobs to be transported thousands of miles away where they are interrogated endlessly to the extent that counsel for the plaintiff hope that the insured and insurer are forced to make terms of surrender. From experience in which thousands, yes, thousands of pages of testimony have been taken in depositions noticed by the plaintiff, harassment must have been a purpose because not one word of this testimony was read or used in the trial of the lawsuits. It takes little imagination to realize what this does to the costs and complications of trial. The same is true of interrogatories. Not one of the eight hundred interrogatories and the defendants' answers was read to the jury by plaintiffs' counsel at the trial. When this point was made in arguments heard in other courts, it made no difference whether the answers were actually used, this was just preparation. The defendant pays for the plaintiff to determine whether or not he has a case. Perhaps some of you have personal knowledge of the unhappy experience of some foreign flag carriers who have been compelled to bring people to the United States for questioning under this deposition procedure. It has been rumored that the harassing tactics paid off rather well when generous settlements were made as the alternative to the continuing pre-trial discovery activities and the trial itself.

Requests to admit are intended to simplify the trial by eliminating matters that must be proved. It is not their function to cover all factual phases of the lawsuit—that is the purpose served by interrogatories and depositions. In a recent aviation case, the plaintiff prepared approximately one thousand requests to admit and the trial judge, instead of throwing them out on numbers alone, as he ought to have done, said that he was glad to set aside a week in a busy period of the court's activity, and did, to hear argument of counsel on the requests, one by one. In the trial of the lawsuit in which those admissions were requested, only one of the thousand and the answer was read to the jury by the plaintiffs. This seems hardly to fulfill the high purpose of making the disposition of litigation more rapid and expeditious.

What has been said is also true of the demand to produce documents and records. Motions are frequently made to produce material prepared years before the accident date. If the airline were forced to produce all the records demanded, months of man hours would be required to collect the material and the results of the work would fill a room. The only avenue for relief is to petition the court and fight to have the motion denied or sharply modified.

Much has been said on the subject of demonstrative evidence in the trial of negligence cases. The use of tangible objects to explain or illustrate a point is not a new trial technique but it has been emphasized in recent years. Demonstrative evidence is intended to exploit the saying that one picture, which can include drawings, diagrams, photographs and the like, is more persuasive than a thousand words. It is not uncommon for counsel to have

the records, documents, and photographs produced in discovery proceedings enlarged to dimensions on the order of eight or ten feet, using these in the examination of witnesses and in the closing arguments to the jury.

The defendant is sometimes called upon to produce wreckage in the court for the trial. The fact that the wreckage may have to be transported thousands of miles at the defendants' expense is not a basis upon which to expect the court to deny the plaintiffs' demand for production of the salvaged remains of the aircraft. In a Grand Canyon accident trial, wreckage and debris were stacked on one side of the courtroom throughout the proceedings. Much of this wreckage would probably have remained in the canyon if it had not been brought out by helicopter, and at some risk, on an expedition to the crash site sponsored by the liability insurer of one of the airlines involved. This sort of demonstrative evidence, exhibiting the broken remains of the aircraft to the jury, is useful for more than its probative value. It serves to recreate the atmosphere of the tragic accident. An eloquent attorney, well briefed on the technicalities of the accident and the significance of the wreckage in the reconstruction of the accident, will talk about the unhappy events which produced the demonstrable evidence of damage on the various bits and pieces of airframe, exciting pity by suggesting the terror of the catastrophe.

Demonstrative evidence is effective, too, in the trial of the issue of damages, especially in bodily injury cases in which there is considerable medical testimony. Whether to permit the jury to see horrifying and repulsive photographs of gruesome injuries is largely a matter of discretion for the trial judge. If such photographs, and they are usually in color, serve no other purpose than to incite the jury, they will be excluded. There is an expression used by some members of the plaintiffs' trial bar, usually in the course of settlement conversations: "Let's not waste time on liability." "With these injuries, all that I need is to get to the jury and we'll have a verdict." What is meant is that if there is a sufficient issue of fact for the judge to submit the case to the jury, a sympathetic jury will not deny his client money damages for a serious injury simply because of weak facts upon which to establish liability. This is not always true and depends upon the type of judge and jury, but a case in our own experience illustrates the point. The injured was a passenger on board an aircraft which, while on its landing roll, was struck by another aircraft as it started its take-off run on the wrong runway. Liability of the owner and operator of the landing aircraft to his passenger for injury sustained in these circumstances seemed most remote. The plaintiffs' attorney, in the trial of that case, devoted little time to the questions relating to liability, but over a period of several days with medical witnesses, he developed a picture of the pain and suffering of his client. Also, by using enlarged charts, the attorney exhibited to the jury calculations of specific amounts which in the view of counsel should be awarded for each minute, hour and day of conscious pain and suffering. This jury returned a jumbo award which was not disturbed on appeal.

This covers the ground, so far as it can be done in these remarks. While the treatment of the subject has been limited and others may have different concepts—it is a controversial subject—the illustrations used are factual and not exaggerated. If it appears to be a one-sided picture, it is because the trend of the experience with which I am familiar is in that direction.

I wish that I had some penetrating, constructive thoughts to leave with you about what can and should be done to shape our course for the future in the handling of claims-legal matters arising out of liability insurance coverages in aviation. Our course has been shaped to a large extent by others —judges, juries, the plaintiffs' trial bar— and by the times in which we live. We cannot turn back the clock, not all the way in any event. There has been much activity, and with some success, in the direction of educating the public, the people who sit on juries, that in the final analysis, they are spending their own money, not someone else's, when they give plaintiffs unjustifiable high verdicts. This is probably most effective in automobile liability cases where insurance rates are given so much publicity and the prospective jurors feel at firsthand the effect of poor loss ratios when they receive notice that payment of their automobile liability insurance premium is due.

In the major crash involving common carriage of passengers by air, we are con-

cerned with very different problems than in the automobile liability accident field. There are complicated fact and legal questions to be disposed of which, if settlements cannot be reached, require a trial. This will be expensive whether the case is won or lost. The preparation requires months of work and the trial itself may last anywhere from one to six weeks, more likely the latter. There are multiple cases to be defended, with a large number of them most dangerous damagewise. Young men, killed or badly injured, who were on the way up in their business careers, survived by a wife and several small children. While ultimately it is up to society to decide the pattern of damages for which they are willing to pay in such cases, from personal afterthoughts on some settlements it seems to us that we must be willing to fight against what experience shows to be unreasonable and unjustifiable demands. The claims-legal side of the business must be willing to take sensible chances in the handling of claims and litigation just as underwriters take sensible risks in writing the business in the first place. Each time that plaintiff's counsel succeeds in bullying insurance people into settlements on his terms, it serves only to encourage him and others to continue with the same tactics. Defendants should not be asked or expected to pay in compromise adjustment, a compromise which eliminates the delay, chance and expense of trial and appeal, sums in the range of the "jumbo" award that a runaway jury might give to the plaintiff at some time in the future after he has incurred expense and overcome a number of obstacles. Plaintiff's counsel pressing this settlement proposal should be invited to prepare and try his lawsuit. The experienced lawyers on the plaintiffs' side of the trial bar know that adjustments cannot be fairly arrived at except in an atmosphere in which both sides are willing to accept the proposition that concessions are a two-way street. If the plaintiff has a yearning anxiety to file suit unless his demands are met, and often this is standard technique, he should be told plainly that there will be no shot gun negotiations in which he makes none of the concessions. This does not imply that claims and legal people representing the insurance industry should handle their dealings with the plaintiffs' trial bar with chips on their shoulders. Such an attitude can lead to bad judgment in making decisions whether to pay or fight, decisions which may seem stupid when examined in retrospect. A realistic approach by defendants early in the case to settlement on a give-and-take basis often can be an effective means of avoiding the enormous, newspaper headline-making award. On the other side of the coin, the plaintiff's lawyer who refuses to open settlement conversations on a realistic basis may be headed for trouble too. It has happened often enough not to be a fortuitous event that at the end of a long, expensive trial the lawyer and his client have considerably less, perhaps even nothing, than would have been available to them if they had converted the claim into money through sensible negotiation. A recent case was tried for seven weeks to have the plaintiff recover less than he could have had in settlement at the outset. Insofar as the client is concerned, actual experience as regards tort litigation is often gained on an unhappy one-time basis.

Defending against unreasonable demands cost money, and in aircraft accident cases it costs lots of money. The money is well-spent, however, if the plaintiffs' trial bar learns that there is a rough and tumble battle to be fought against competent well-prepared adversaries when the unqualified demand is for a "jumbo" settlement. The many factors involved in reaching claim settlements are controversial stuff and subject to a variety of opinions. It is easy to second-guess what others have done and are doing. Hind sight is not necessary, however, to know that strong inducements to settle are created when plaintiff's counsel knows that he has a tremendous task of preparation and trial ahead which can be quickly resolved through compromise settlement. No inducement for an early settlement exists when plaintiff's counsel has reason to believe that arrogant and brash tactics will soften up his opposition to a situation where the defendant will want to accept settlement on any terms he can get. Defense of Warsaw Convention litigation in the U.S.A., the Jane Froman and related cases[21] and the Warsaw Convention cases before and since the Froman case[22]

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[21] *Ross et al., v. Pan American Airways, Inc.*, 2 Avi 14,556, 14,911; cert. denied 349 U.S. 947.

[22] Such as, *Wyman et al., v. Pan American Airways, Inc.*, 293 N.Y. 878, cert. denied 324 U. S. 882. *Noel et al., v. Linea Aeropostal Venezolana*, 154 F. Supp. 162, aff'd. 247 F. 2d 677, cert. denied 78 S. Ct. 334.

are useful examples of the laying out of money, considerable sums, to prepare the best defense possible against the attempts to break through the ceiling imposed on the amount recoverable. Those efforts have paid off many times on the original investment by establishing legal precedents in the trial and appellate courts which have deterred others from similar action knowing the probable outcome would be against them. Not all aircraft liability insurers and their airline insureds subscribe to this philosophy of defense. No doubt some of you are acquainted with Warsaw Convention claims which were closed by payments in excess of the limitation on liability simply because the plaintiff's lawyer was giving someone a hard time.[23]

I regret, too, not to be able to leave you with some cheering news. Not all of our cases are of a grim nature. We do have an occasional laugh. I am reminded of the young man, who ticketed to San Francisco, was permitted through the gate and on board an aircraft destined non-stop to, and which ultimately landed at, Las Vegas. Upon arrival and looking out of the window, he asked the stewardess, in some bewilderment, "Where are we?" The lawsuit filed against the airline for misdirecting him included an item of damages that his fiancee broke off their engagement because she did not think anyone so stupid as to become involved in this misadventure would make a good husband. Where are we, indeed, gentlemen?

[23]Notably absent from these remarks is reference in particular to the problems of the injured and families of those killed. Considering contingent fee contracts and the high cost to prepare and try negligence cases those who have suffered loss must often wonder at the end whose case it really was. More premium dollar is often spent on litigation, that is, money for fees, costs and expenses of both sides, than ultimately finds its way into the pockets of the plaintiff. While these remarks are necessarily concerned with the litigation aspects of negligence claims after suits have been filed, and the push and shove of adversary proceedings, most responsible insurance companies in the casualty field recognize that people who have been damaged are owed the obligation of a prompt and fair appraisal of their claim.

# Shopping Center Financing by Life Insurance Companies–Some Pitfalls for the Investor

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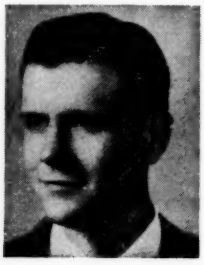

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THE ERECTION of shopping centers in this country and Canada has been one of the major commercial developments of the past decade. Funds of life insurance companies have been an important source of capital for financing the construction and development of shopping centers throughout this country and life insurance companies organized in this country have also invested substantial sums in shopping centers located in Canada.

Various methods of financing and investment are used, the most common being through mortgage loans.[1] At the end of 1957 total mortgage holdings of life insurance companies amounted to $35.2 billion.[2] From the amount of life insurance company funds which have been and are being invested in shopping centers one can conclude that this type of investment satisfies a fundamental objective of life insurance company investment policy–safety of principal and diversification as to geographical location. At least this is the considered judgment of life insurance company investment executives.

Because of the variety of methods for financing shopping centers and the numerous problems (both legal and economic) encountered in each method this article will be confined to the most common method of financing used, namely, the mortgage loan.

Unlike the traditional commercial loans of the past (downtown properties in the 90% to 100% retail or business districts), the safety of a loan upon or an investment in a shopping center property depends at least as much upon the credit of the tenants or other occupants of the property as it does upon the location of the real estate and its value resulting therefrom. Accordingly, life insurance companies are vitally concerned with the identity of the prospective tenants or occupants of the shopping center, their credit standings and the terms and provisions of the leases or other agreements under which they will occupy space in the shopping center. Of course, the location of the real estate which will secure a shopping center loan is important from the standpoint of the prospective customer potential of the area selected, the presence of other competing businesses, including other shopping centers, and ready access to the shopping center from public streets or highways, and the resulting value of the real estate is important because it determines the amount of loan that a life insurance company may make pursuant to the investment statute of the jurisdiction where the property is located or where the life insurance company is incorporated.[3]

[1] In addition, the investment of life insurance company funds may be by the purchase of stock, bonds, notes or debentures of the sponsor or developer, the outright purchase or ownership of the shopping center premises by the life insurance company, with or without a lease of the premises to the sponsor or other operator, the acquisition by the life insurance company of a leasehold interest in the shopping center or a combination of the above methods.

[2] Life Insurance Fact Book, p. 80 (1958). It was estimated that life insurance companies had in excess of $1 billion invested in loans to shopping centers by the middle of 1958. According to the International Council of Shopping Centers, there were approximately 2500 shopping centers in operation in the United States at the beginning of 1958 with an additional 1400 projected for construction during 1958 and 1959.

[3] Life insurance companies who desire to transact business in New York state must also comply with the provisions of the New York law applicable to investment of domestic life insurance company funds. See Insurance Law, § 90 which provides, in part as follows:

Assuming that the life insurance company is satisfied with the economics and legality of a proposed loan to a shopping center sponsor or developer and has issued a commitment to make a loan, the first problem which the life insurance company lawyer (either home office counsel or designated local counsel) usually encounters is examination of the leases or proposed leases.[4] It will also be necessary for the title to the real estate to be examined. This may involve an examination of an abstract of title, a title report or binder issued by a responsibile title insurance company, a torrens certificate of title, or the examination of the original land records, together with the examination of a plat of survey.[5] The lawyer may be required to examine a ground lease if the proposed loan is to be secured by a leasehold interest. Assuming that title is or can be made acceptable to counsel for the life insurance company, counsel will devote the major part of his time to examination of the leases. He must determine whether or not they comply with the life insurance company commitment as to tenant,[6] term, rental and area. He must determine whether they are or will be prior or subordinate to the life insurance company mortgage and the effect which a foreclosure of the mortgage would have upon the leases under the law of the particular jurisdiction involved.[7] He must determine whether the tenant has an option or right to cancel or terminate the lease as a result of fire or other casualty, condemnation, default by the landlord, because of cancellation of other leases in the shopping center, violation of exclusive clauses or for other reas-

[4]Construction financing of shopping centers is usually supplied by local sources (banks, trust companies or mortgage companies). Many times the interim lender requests the life insurance company to enter into a so-called "Buy and Sell Agreement" which obligates the life insurance company to purchase and the interim lender to sell the interim loan. These agreements require careful drafting and examination by life insurance company counsel to be certain that they comply with the terms of the life insurance company loan commitment.

[5]Because of the size of shopping center loans and their location near large suburban and metropolitan areas by far the greatest number of the titles are insured by title insurance policies.

[6]Life insurance company counsel should be certain that the tenants which are required to lease space in the shopping center by the terms of the loan commitment are directly liable on the leases, as tenants, rather than guarantors thereof. There may be a difference in the limit or extent of liability of a person, as tenant, and that of the same person, as guarantor, under a lease. For example, a guarantor's liability under a lease guarantee may be limited to the same extent as the liability of a tenant involved in bankruptcy, re-organization, arrangement or similar proceedings under the provisions of the federal bankruptcy statutes, where the lease terminates as a result thereof. See 3 Collier Bankruptcy, Par. 63.33, at 1910 (14th ed. 1956) and cases cited therein.

[7]In some jurisdictions, New York for example, foreclosure of a mortgage will not cancel or terminate a subordinate lease unless the tenant is made a party to the foreclosure action. *Hirsch v. Livingston* 3 Hun (N.Y.) 9 (1874); *Home Life Ins. Co. v. O'Sullivan et al.*, 151 App. Div. 535, 136 N.Y. Supp. 105 (1912). In other jurisdictions, Michigan for example, foreclosure of a mortgage will cut off or destroy all subordinate leases automatically. *Dolcsa v. Bellows-Claude Neon Co. et al.*, 261 Mich. 57, 245 N.W. 569 (1932). The life insurance company will at least want the key or prime leases not in default to be preserved in the event of foreclosure, because, as pointed out above, the leases and the credit of the tenants are important in assuring the safety of this type of loan or investment. Thus, in jurisdictions which follow the New York rule, the life insurance company mortgagee will usually require the leases to be subordinate to the mortgage (either by the terms of the lease or by agreement between the mortgagee and the tenants) because this will give the mortgagee the opportunity to elect, at the time of foreclosure, which leases it may wish to terminate by the foreclosure proceedings and which leases it may wish to preserve. In jurisdictions following the Michigan rule the life insurance company must decide at the time of making the loan which leases it wants to preserve in the event of foreclosure. The life insurance company mortgage would have to be subordinate to any such leases (either by agreement between mortgagee and the tenants, by reason of the lease being prior because of earlier execution, by an appropriate provision in the mortgage or other security instrument, or otherwise).

"§90. Investments of foreign and alien insurers.

1. The superintendent may refuse a new or renewal license to any foreign insurer, if he finds that its investments do not comply in substance with the investment requirements and limitations imposed by this chapter upon like domestic insurers hereafter organized to do the same kind or kinds of insurance business. For the purposes of this subsection, the investments of a foreign insurer shall be deemed to comply in substance with the investment requirements and limitations imposed by this chapter upon like domestic insurers hereafter organized to do the same kind or kinds of insurance business if, after disallowing as admitted assets in whole or in part of any of its investments which do not comply with such investment requirements and limitations, the superintendent finds that the resulting surplus to policyholders of such foreign insurer would not be reduced below an amount which is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs; but in no event below an amount equal to the minimum surplus to policyholders required on organization of a domestice insurer to do the same kind or kinds of insurance business. * * *".

For the New York statutory provision relating to permissible mortgage loan investments see Insurance Law, §81 (6) (a).

ons. He must determine whether the lease creates any lien rights against the landlord's estate in favor of the tenant which would be prior to the lien of the life insurance company mortgage or whether the tenant has an option to purchase either the demised premises or the entire shopping center property under circumstances which would not insure payment of the life insurance company mortgage if the option were exercised.[8] He must determine whether there are any clauses in the lease which would affect the rental or income from the property by decreasing the required amount of rent, such as provisions for abatement or offsetting against rental advances made by or expenses incurred by the tenant on behalf of the landlord or otherwise. He should determine whether the lease provides for a division between lessor and lessee of the award in case of condemnation and whether there are restrictions upon the use of the award or the use of fire insurance proceeds by the owner or mortgagee, i.e., whether they must be applied toward the resoration of the improvements. He must determine whether the leases contain a proper description of the demised premises, are validly executed according to the requirements of local law and constitute legally binding contracts or agreements in all respects[9] and whether or not recording is necessary in order to protect the rights of the landlord, the mortgagee, as conditional assignee of the lease, or the tenant against the interests or rights of third parties without actual notice of the lease. The life insurance company is vitally concerned with assuring itself that the important or prime leases are firm or non-concellable during their entire term or the term of the loan, as the case may be, or putting itself in a position by protective covenants in the security instrument or by separate agreement with the tenants to prevent a cancellation or termination of these leases.

One of the most important considerations in making shopping center loans, not only from the standpoint of the owner and the tenants but also from the standpoint of the life insurance company, is whether the shopping center will have adequate parking area and whether there is adjacent land available for the future expansion or development of improvements or the parking area, if this becomes necessary or desirable, or for the alteration or rearrangement of existing improvements and parking area in case the size of the shopping center is reduced by condemation. Additional building is usually restricted either by one or more of the leases or by the mortgage, deed of trust or other security instrument. In this connection, it is desirable for the leases to permit the landlord some leeway in the erection of additional improvements or the alteration or rearrangement of existing improvements provided the parking area is not reduced below a specified minimum. This will avoid the necessity of securing consents from the tenants at a later date if additional improvements, or alterations or additions to the existing improvements (whether pro-

[8]Some leases give the tenant a right of first refusal to purchase either the demised premises or the entire shopping center premises. These provisions usually give the tenant the right to meet the terms of any bona fied offer to purchase which the landlord may receive as well as a prior right to make an offer if the landlord decides to sell the premises. These provisions are not looked upon with favor by life insurance companies because they may undully restrict the life insurance company in disposing of the security after it has acquired title thereto through foreclosure or otherwise.

[9]In this connection, attention is called to an interesting case in California, *Haggerty v. City of Oakland*, Cal. App., 326 P. 2d 957 (1958). In this case the City of Oakland entered into a lease of a building to be constructed pursuant to a resolution and ordinance adopted by the City's Board of Port Commissioners and ordinance of the City Council ratifying this action. The lease was for a term of 10 years commencing from the completion of the building and required the board to construct the building (a convention hall and banquet building) with "due diligence". In a taxpayer's suit for injunction and declaratory relief it was contended that because the lease was not to commence until completion of the building (which event is uncertain and indefinite) it could conceivably occur later that twenty-one years after a life in being, and thus violate the rule against perpetuities. Section 715.2 of the California Civil Code provides, in part: "No interest in real or personal property shall be good unless it must vest if at all, not later than twenty-one years after some life in being at the creation of the interest * * *." From a judgement for the city in the trial court the taxpayer appealed. The California District Court of Appeals, First District, held that the rule against perpetuities applies to leases, that the rule had been violated in this case and that the parties must renegotiate the lease if that was what they desired to do. Many shopping center leases provide for commencement of the term upon completion of specified improvements. If these leases affect property in a jurisdiction where the rule against perpetuities is similar to the rule in California and the leases do not provide for a definite date after which all rights shall terminate, it would seem that they should provide for execution of (or the parties to the lease should voluntarily agree to execute) a supplemental agreement fixing the commencement date of the lease when it is finally determined.

vided for in the leases or not), are to be constructed. It is also desirable for the landlord to reserve the right in the leases to rearrange the parking area and to substitute parking area in place of area which may be condemned either by erecting ramps, doubledecking the existing area or providing for the development of adjacent land. The area or size and layout of the land upon which the shopping center improvements are to be erected are an important consideration with respect to this problem of adequate parking facilities and in assuring ready access to the shopping center improvements.

Shopping center financing can present numerous and difficult problems for the life insurance company if the ownership of the center is divided between several interests or if there are several lenders financing one large center either with single or divided ownership.[10] This situation can arise in a number of ways. Some large tenants (either national or local) have a policy of owning the portion of the shopping center upon which their stores are to be erected. Some centers are so large that the ownership may be divided between different corporations or entities for tax reasons, or the amount of the loan required to finance the center may be so large that one life insurance company would refuse to make the entire loan. In situations of this kind the life insurance company counsel not only has to be concerned with the title and provisions of the leases affecting the portion of the center which will be the security for his company's loan, but the rights which the adjoining owners and tenants (their successors and assigns) and the occupants, guests, invitees, etc. of the other portions of the center have in his company's security, as well as the rights which the owner of his company's security and the tenants (their successors and assigns) and the occupants, guests, invitees, etc. have in the adjoining property. This may require the drafting or examination of complicated agreements dealing with reciprocal parking, ingress and egress, and other easement rights, the examination of title to the adjoining parcels and the leases of all or portions of the adjoining parcels.[11] Life insurance company counsel must be careful in the examination of the leases of portions of the security for the life insurance company mortgage, in cases where the mortgage is to cover only a portion of the shopping center, to determine what rights, if any, have been given or granted to the tenants in those portions of the shopping center which will not be included in the life insurance company mortgage so that the mortgage will give the mortgagee similar rights. Many times the leases on the adjoining parcels have provisions which may require affirmative action with respect to the life insurance company security or which could result in a termination of the leases of portions of the security if certain action is not taken with respect to the adjoining parcels. For example, a life insurance company might be involved in financing a shopping center in which a large national concern is to occupy one of the buildings, but another lender is to finance the portion of the center upon which this large national concern's building is to be located. Let us assume that the ownership of the two adjoining parcels is the same. The life insurance company lender would not be particularly concerned with the term or rental of the lease to the large national concern because this lease would not be conditionally assigned to the life insurance company as additional security for its loan. However, an examination of this lease could disclose provisions which might affect

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[10]New York statutory law would prohibit several life insurance companies from participating in the financing of a shopping center (or any other type of real estate security) except on the basis of separate loans secured by separate mortgages on different portions of the same property. See Insurance Law, §81 (6) (a).

[11]Where several lenders are financing different portions of one large shopping center, whether or not the different portions are owned by one person or by different persons or entities, a satisfactory agreement or declaration establishing reciprocal parking, ingress, egress and other easement rights between the different portions of the shopping center is essential to the successful operation of the shopping center on an integrated basis, and to make the separate portions of the shopping center acceptable as security for the several loans. A life insurance company would be unwilling to accept as security for a loan a portion of a shopping center without a satisfactory agreement or declaration establishing such reciprocal easement rights. The agreement or declaration should be binding upon all parties having any rights or interest in the various portions of the shopping center, and should cover in a satisfactory manner, among other things, the matter of maintenance and repair of the parking or other common area, the matter of restricting additional building in the shopping center, should provide for substitution of parking or other common area in place of such area as may be taken by eminent domain, and should provide for the expansion of the parking or common area in case additional improvements are erected.

the life insurance company's security. Let us further assume that the lease to the large national concern specifically describes the premises which are to be occupied by this tenant, then, as is customary, grants parking, access and other easement rights to this tenant in the adjoining parcel (which is to be the security for the life insurance company loan). The lease further provides that if the building on the demised premises is damaged or destroyed by fire or other casualty or is condemned, in part, the landlord must restore the premises unless the tenant elects to cancel the lease, which it can do if the destruction or taking is substantial. In addition, and subject to the same right of cancellation, the lease also provides that if any of the buildings upon the adjoining parcel (which is to be the security for the life insurance company loan) are damaged or destroyed or condemned, in part, the landlord must restore or rebuild said buildings, or the remaining portion, to a complete architectural unit in substantially their condition immediately prior to said damage, destruction or taking. In addition to the right of cancellation given to the tenant in the situation assumed above, the tenant is given the right to restore or rebuild the improvements and either offset the amount advanced against future rent or otherwise collect it from the landlord. Because of the above lease provisions the life insurance company, as lender, would be faced with the following problems, among others:

(1) If the large national tenant elected to terminate its lease, would this give any of the tenants of portions of the security for the life insurance company mortgage the right to terminate their leases?

(2) If the life insurance company became the owner of its security through foreclosure, deed in lieu of foreclousre, or otherwise, could it be compelled to restore the improvements upon any part of the shopping center not included in its mortgage, i.e., could it be compelled to restore the improvements upon the adjoining parcel, or, if it were in the position of mortgagee, could the large national tenant of the adjoining parcel assert any lien rights against the security for the life insurance company loan that would be prior to or ahead of the life insurance company mortgage in the event the landlord refused or was unable to restore or rebuild the improvements, and the large national tenant did so and failed to receive reimbursement from the landlord?

In order to answer the first question it would be necessary to completely review all of the leases. The answer to the second question would depend upon the answer to a few preliminary questions, such as whether the covenant to restore or rebuild runs with the land and whether the life insurance company would be in privity of estate with the large national tenant if it acquired title to the property securing its mortgage. It is clear that the life insurance company (if it acquired title to the portion of the center which was security for its loan by foreclosure or otherwise) could, by virture of the above provisions, be compelled to restore the improvements upon the portion of the center so acquired. While it is held in at least one American jurisdiction that affirmative covenants do not run with the land, even in this jurisdiction there are a number of exceptions.[12] However, by the great weight of authority no distinction is made between affirmative and negative covenants in determining whether or not they run with the land.[13] The life insurance company would not, of course, occupy the position of landlord to the large national tenant of the adjoining property (and, therefore, not be in privity of estate with said tenant), if it became the owner of its security through foreclosure or otherwise, except to the extent that it owned land in which this tenant had parking, access, and other easement rights. Because of such parking, access and other easement rights, it could be argued that the land affected by such easement rights and comprising a portion of the security for the life insurance company mortgage was a part of the premises demised to this national tenant. However, the life insurance company lender would only acquire ownership to a portion of the demised premises and could not be considered to occupy the po-

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[12]3 Tiffany Real Property, §854, at 458-459 (3d ed. 1939).

[13]See footnote 12 *supra*. Also see *Chamberlain v. Dunlop*, 126 N.Y. 45, 26 N.E. 966 (1891) (holding covenant to rebuild in case of fire runs with the land); *Hight v. McCulloch*, 150 Tenn. 117, 263 S.W. 794 (1924) (covenant to repair buildings on leased premises runs with the land); *Chambers v. Lindsay*, 171 Ala. 158, 55 So. 150 (1911) (burden of landlord's covenant to repair runs with reversion); for statement of Michigan Supreme Court that covenant to repair runs with the land, see *Detroit Trust Co. et al., v. Mortensen et al.*, 273 Mich. 407, 263 N.W. 409, 410 (1935).

sition of landlord and be considered in privity of estate with this tenant except with respect to the property in which such parking, access and other easement rights existed. Therefore, it would appear that the life insurance company could not be compelled to restore the improvements, except upon portion of the center which it acquired, on the theory of apportionment of the covenant or obligation to rebuild.[14] It would still be necessary to determine whether the large national tenant of the adjoining parcel could assert any lien rights against the life insurance company's security (if this tenant advanced money to rebuild improvements upon the life insurance company's security and was not reimbursed by rental offset or otherwise) that would be prior to or ahead of the life insurance company's mortgage, in the event the life insurance company was still a mortgagee. In attempting to find an answer to this latter problem it would be necessary for the life insurance company counsel to examine the laws and court decisions of the jurisdiction in which the property securing the mortgage loan was located. There are several court decisions which might give some indication how the courts would look at this problem. In an Illinois case,[15] the lessor was obligated under a lease to repair or rebuild in case of damage by fire and the tenant, in addition to other remedies, had the right to terminate the lease. The property was destroyed by fire and the leassee requested the lessor to rebuild. When the lessor refused, the lessee put up a new building. The court held that the lessor was bound to rebuild, and, upon failure to do so, the lessee could make the necessary repairs and charge them to the lessor. The court further held that even though there was no agreement between the parties for a lien and even though there was no express covenant in the lease giving the lessee the right to make repairs or rebuild, or requiring the lessor to reimburse the lessee for repairs made by lessee which the lessor was required to make, the lessee had an equitable lien which could be enforced against the lessor's property. If a court would go this far in recognizing an equitable lien in a case where the lease did not specifically give the lessee the right to make repairs or rebuild or require the lessor to reimburse the lessee for repairs or rebuilding done by the lessee, it is conceivable a court would not only recognize that an equitable lien existed in favor of the lessee, but might, if the lease were prior to the life insurance company mortgage and expressly gave the lessee the right to make repairs or rebuild and to be reimbursed therefor, decide that the equitable lien was prior to the mortgage. In another case,[16] which involved an appeal to the Circuit Court of Appeals, Sixth Circuit, from the District Court of the United States for the Northern District of Ohio, Eastern Division, the court not only held that a lessee had a right to a lien, but held that it was prior to the lien of a mortgage on the fee. Under the lease involved in this case, the lessee agreed to build buildings for his own purposes and upon termination of the lease the lessor agreed to purchase them for their value to be determined by an agreed method set forth in the lease. The lease was recorded and the buildings erected. The lessee mortgaged his leasehold estate and the lessors mortgaged their fee interest subject to the lease, and excepted therefrom the buildings. The property was subsequently sold subject to the lease and to the leasehold mortgage, and the fee mortgage was later discharged. A new mortgage was placed on the fee to which the leasehold mortgage was subordinated. The lessee's widow, who had succeeded to his interest, elected to terminate the lease, as provided therein, and appraisers were appointed to determine the amount due her for the buildings. Before payment was made, the fee mortgagee began foreclosure proceedings. The widow claimed that she had an equitable lien for the value of the buildings which was prior to the mortgage on the fee. The court upheld her contention. The court found that the fee mortgagee had notice of the recorded lease, had knowledge of the deed by which the mortgagors acquired title, expressly recited that the conveyance was subject to the lease as well as to the leasehold mortgage, and had notice of the rights of the lessee in the buildings because of the earlier fee mortgage which excepted the buildings. It further held that because of the provisions in the default clause of the lease permitting the landlord to re-enter only if it purchased the buildings the lessee had the right to retain possession of the premises as security until paid for the buildings. The Supreme

[14]Restatement of of the Law of Property, §536.

[15]Oppenheimer v. Szulerecki, 297 Ill. 81, 130 N.E. 325 (1921).

[16]Massachusetts Mutual Life Insurance Co. v. Jeckell et al., 124 F. 2d 339 (Cir. 1941).

Court of Michigan[17] has held that an equitable lien cannot arise where the party advancing money can elect whether it will or will not do so. Under the assumed provisions of the lease to the large national concern mentioned above, the tenant was not bound to advance any money for repairs but could do so at its option. If the proposed loan by the life insurance company were to be made on Michigan property or in a jurisdiction following the Michigan rule, it could be concluded, if the life insurance company were still mortgagee, that the tenant of the adjoining parcel could not assert any lien rights against the life insurance company's security that would be ahead of or prior to the life insurance company's mortgage. This same conclusion might not be applicable in a jurisdiction following the rules laid down by the Illinois court or the circuit court of appeals mentioned above. Even in a jurisdiction following the Michigan rule, the life insurance company lender would still have the practical consideration of whether it would want to take subject to the obligation of its mortgagor to rebuild the improvements located upon its security or to assume this obligation itself, it acquired title thereto, when it might be more appropriate or advantageous to postpone such rebuilding or, perhaps, to make some entirely different use of the property or of the insurance or condemnation proceeds.

Another type of divided ownership which can present difficult problems for the life insurance company investor is the situation where the borrower has the fee title to a portion of the shopping center and a leasehold interest in the remainder of the center, or the borrower is the owner of a leasehold estate in the entire shopping center property. In either of the situations mentioned above it is sometimes necessary for the fee owner to join in the execution of the mortgage or deed of trust, either because the leasehold estate does not qualify as a legal investment under the investment statutes of the jurisdiction where the property is located or where the life insurance company is incorporated,[18] or for appraisal reasons. It is sometimes necessary for the sponsor or developer, in order to raise the necessary capital, to sell the fee and to create a ground lease in its favor. As stated above, it may be necessary for the fee owner to join in the execution of the mortgage or deed of trust. When this is done, the initial reaction of the life insurance company counsel is to consider the loan the same as an ordinary fee loan and not to be too concerned with the provisions of the ground lease or the inclusion of the protective covenants and provisions usually inserted in a mortgage or deed of trust covering only a leasehold interest. However, since the leases are so important in shopping center loans, and, since, in the above circumstances, the leases are generally entered into between the ground lessee, as lessor, and the various shopping center occupants, as lessees, one can see upon reflection that it is important to preserve the leasehold estate as security for the loan in order to preserve the sub-leases and to prevent them from being terminated because of cancellation or termination of the ground lease. This could arise because of the termination or forfeiture of the ground lease by the fee owner due to a default by the ground lessee or the termination of the ground lease resulting from a merger by a union of the title to the fee and leasehold estates in the same person purchasing both estates at a sale pursuant to foreclosure of the mortgage or deed of trust against both the fee and leasehold estates. The above result can be avoided if there is an appropriate provision in the ground lease whereby the fee owner agrees that all leases entered into by the ground lessee will be binding upon the fee interest and that a cancellation or termination of the ground lease will not affect any such sub-leases. If the ground lease does not contain such a provision (in most cases it does not), and, if it is ahead or prior to the sub-leases, it is desirable to secure a separate agreement between the fee owner and the various sublessees to this effect and to include a corresponding or supplemental provision in the mortgage or deed of trust to the same effect. Let us suppose, for example, that a corporate applicant for a mortgage loan on the fee interest in a shopping center, in order to raise the needed capital, transfers its fee interest in the shopping center to another corporate entity and then takes back a ground lease of the property. Assume that some of the leases submitted for examination are executed by the ground lessor, as lessor, but that most of them are executed by the ground lessee, as lessor,

[17] Cheff v. Haan, 269 Mich. 593, 257 N.W. 894 (1934).

[18] The investment must also be in substantial compliance with New York law. See footnote 3, *supra*.

and are dated and executed subsequent to the date and execution of the ground lease. The life insurance company decides to make the loan provided it obtains a mortgage covering the interest of both corporations in the property, i.e., both the fee and leasehold interests. Let us further assume that the ground lease does not specifically provide that the sub-leases made by the ground lessee will be binding upon the ground lessor's fee simple estate. It would be advisable in these circumstances to have the ground lease amended to provide that the sub-leases subsequently executed by the ground lessee, as lessor, would be binding upon the ground lessor's estate and would not be terminated or cancelled if the ground lease were terminated or cancelled. It would also be advisable to require the ground lessor, ground lessee and all the subtenants under the sub-leases which had already been executed to enter into a separate agreement to the same effect. In addition, a corresponding covenant could be inserted in the mortgage (which would be executed by both the ground lessor and ground lessee) to the effect that a termination of the ground lease, whether by action of the ground lessor pursuant to default by the ground lessee, or resulting from a merger by union of the fee title and leasehold in the same person, or otherwise, would not result in a cancellation or termination of the sub-leases.

One type of provision found in many shopping center leases to which life insurance company lenders must give serious consideration is the so-called "exclusive clause" or similar provision restricting in some manner the number and type of competing businesses or competing departments which may be operated by other tenants or occupants in the shopping center.[19] In many cases the tenant is given the right to terminate the lease for a violation of such a clause or provision. The life insurance company mortgagee may obtain some protection against the operation of this type of exclusive clause or restriction provision by requiring the leases containing such clause or provision to be recorded, or, requiring the recording of a separate instrument setting forth such clause or provision in full. Recording of a lease containing a provision restricting competition in the property, of which the leased premises form a part, has been held to constitute constructive notice of such restrictive provision to third persons dealing with such property and they will be bound to observe such restriction.[20] In addition, the life insurance company mortgagee can include a protective covenant in the mortgage, deed of trust or other security instrument requiring the owner-mortgagor to observe and comply with such an exclusive clause or restrictive provision and reserving to itself, as mortgagee, all rights and remedies of the owner-mortgagor to prevent or cure violations thereof by injunctive relief or otherwise. The difficult problem arises when the lease attempts to prevent or restrict competition or use of land or property which the sponsor or developer may own or may subsequently control or acquire and which is not a part of the shopping center property offered as security for the proposed loan. As pointed out above, the restrictive provision can be made a matter of record, but such recording would only restrict the property which the sponsor or developer owned at the time of recording. About the only protection the life insurance company can secure in a situation of this type is to require the lease or other document containing the exclusive or restrictive clause to be made a matter of record against all property owned or controlled by the shopping center sponsor or developer together with a covenant or agreement (usually contained in the mortgage, deed of trust or other security instrument) on the part of the owner to record a similar restriction against any other property subsequently acquired. Of course, a protective covenant similar to the one suggested above, in cases where the exclusive clause or restrictive provision applies only to the shopping center property which will be included in the life insurance company mortgage, should be included in the mortgage, deed of trust or other security instrument.

The same type of security instruments containing many of the standard provisions

[19]Such covenants in leases have been held valid and enforceable in a number of cases. *Vanover v. Justice,* 180 Ky. 632, 203 S.W. 321 (1918); *Herpolsheimer et al., v. Funke et al.,* 1 Neb. 304, 95 N.W. 687 (1901); and *Pyle & A. Co. v. Hippodrome Bldg. Co.,* 23 Ohio Cir. Ct. N.S. 331, 44 Ohio Cir. Ct. 273 (1912).

[20]See *Pyle & A. Co. v. Hippodrome Bldg. Co., supra.* Of course, third persons with actual knowledge of the exclusive clause or restrictive provision are bound thereby. *Aiello Bros., Inc. v. Saybrook Holding Corporation et al.,* 106 N.J. Eq. 3, 149 Atl. 587 (1930); and *Waldorf-Astoria Segar Co. v. Salomon, et al.,* 109 App. Div. 65, 95 N.Y. Supp. 1053 (1905), aff'd, 184 N.Y. 584, 77 N.E. 1197 (1906).

found in mortgages, deeds of trust, assignments of lease, etc. which are used for loans upon downtown commercial properties are often used in shopping center loans. However, because of the problems mentioned herein and others which shopping center loans can present to the investor, it is necessary in most cases to include special covenants and provisions in the security instruments for the protection of the life insurance company mortgagee, and, in many cases, to require special types of instruments or agreements.[21] While shopping center loans for purposes of classification are considered commercial loans, from what has been said above, it is obvious that they do not conform to the traditional pattern of the commercial loans of the past.

[21]Some examples of special covenants which may be required in the mortgage, deed of trust or other security instrument are: (1) a covenant restricting erection of additional improvements which would reduce the parking ratio below a specified minimum; (2) a covenant requiring the mortgagor to comply with the provisions of all leases of portions of the security applicable to the landlord and to require the mortgagor to exercise all rights available to make the tenant comply with the lease provisions applicable to the tenant and giving the mortgagee the right to perform such provisions or exercise such rights if the mortgagor fails to do so; (3) a covenant requiring the mortgagor to comply with all "exclusive clauses" contained in any leases of portions of the security, with the provisions of such clauses set forth in full in the security instrument if they do not otherwise appear in any recorded document; (4) a covenant to the effect that a cancellation or termination of the ground lease will not result in the cancellation or termination of the sub-leases assigned to the life insurance company lender as additional security where the mortgage is to cover both the fee and leasehold interest in a shopping center; and (5) a covenant requiring the mortgagor to furnish annual audits and a list of the tenants occupying space in the shopping center showing their respective gross sales volumes and rentals paid.

Some examples of special agreements which may be required are: (1) a "buy and sell agreement" between the life insurance company making the permanent investment and the interim lender furnishing the construction financing; (2) an agreement covering reciprocal parking, ingress, egress and other easement rights where the life insurance company lender has only a portion of the shopping center as security for its loan; (3) agreements between the life insurance company lender and the tenants subordinating the mortgage to the lease or lease to the mortgage or concerning provisions of the leases whereby the life insurance company will receive notice and an opportunity to cure defaults of the mortgagor-lessor in order to prevent a cancellation of such leases; (4) an agreement by a guarantor of a prime lease, whose credit is being relied upon, that the guarantor will enter into a new lease on the same terms and at the same rental as the lease guaranteed, for the unexpired term thereof, in the event said lease is terminated by its terms or by action of the trustee or other liquidating agent as a result of bankruptcy, reorganization, arrangement, insolvency or similar proceeding involving the tenant.

# The Case for Private Insurance of Workmen's Compensation*

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THE OVERALL TITLE of this discussion, "State Funds v. Private Insurance," is broad enough to permit a variety of positions. The proponents of state insurance can contend that private insurance of workmen's compensation should not be permitted. The proponents of private insurance could urge the abolition of all state workmen's compensation funds, monopolistic and competitive. The real issue is whether the objectives of a modern system of workmen's compensation can be best accomplished by state insurance or by private insurance. Whether a competitive state fund, operating on the same terms as private insurers, is in public interest, is another question, not argued herein.

The objectives of a modern workmen's compensation law may be stated as follows:

1. To secure to injured workers and the families of deceased workers the prompt payment of weekly benefits in lieu of lost wages;
2. To provide injured workers with adequate medical and hospital care;
3. To rehabilitate workers suffering serious injuries;
4. To promote the prevention of work injuries;
5. To provide employers at reasonable cost a means of securing the performance of the above obligations.

The insurance device, whether public or private, is necessary to accomplish these objectives. The proponents of private insurance believe that experience in the United States demonstrates that it is in the public interest that private insurers be allowed to write workmen's compensation insurance.

At the present time seven of our states have monopolistic state compensation funds.[1] In eleven states, state funds compete with private carriers for workmen's compensation business.[2] In the remaining thirty-one states all workmen's compensation insurance is written by private carriers. In the eleven states with competing state funds most of the business is written by private carriers, and this is true even in states such as California and New York with aggressive, well-managed state compensation funds. The question of whether workmen's compensation insurance should be a state monopoly or written by private carriers was carefully considered by various commissions and by state legislatures when our first workmen's compensation laws were adopted. A majority of the states chose private insurance. When given the opportunity to choose between private insurance and state insurance, the majority of employers choose private insurance. It follows that the proponents of state insurance carry the burden of proving that state insurance will accomplish, better than private insurance, the objectives of a modern workmen's compensation system.

The arguments commonly advanced in favor of state fund insurance are these:

1. A state fund affords security superior to that given by private insurance.

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[1]Nevada, North Dakota, Ohio, Oregon, Washington, West Virginia, Wyoming.

[2]Arizona, California, Colorado, Idaho, Maryland, Michigan, Montana, New York, Oklahoma, Pennsylvania, Utah.

2. A state fund pays compensation benefits more promptly.
3. A state fund provides better medical service.
4. A state fund gives better loss prevention service.
5. From the standpoint of workers, states with monopolistic state funds have more generous compensation laws.
6. A state fund gives employers better protection.
7. State fund insurance is cheaper.

Let us examine each of those arguments critically, not from a theoretical or legal standpoint, but from a comparison of the actual performance of state funds and of private insurance carriers.

Each of our state workmen's compensation laws, except that of Louisiana, requires an employer subject to that law to provide security for the payment of compensation benefits to his employees. Subject to differences in the laws of the several states, that security is provided in one of three ways—by private insurance, by state insurance, or by self-insurance. Because self-insurance is outside the scope of this article, this discussion will be limited to a comparison between the security afforded by private insurance and that afforded by a state fund.

The formal commitment by statute of a state's credit to secure the obligations of its compensation fund would constitute security that private insurance would find it difficult to match. No state affords such a guarantee. It may be assumed, however, as a fact of political life, that no state fund will be permitted to fail under circumstances that cause compensation beneficiaries to suffer; this is what one authority describes as the "implicit" basis upon which a state fund's guarantee of security rests.[3] Nevertheless, some state funds have gone through experiences which would have meant the liquidation of a private insurer.[4] Further, it is a matter of record that at the depth of the depression in the early thirties some state and municipal governments postponed the payment of their obligations or paid in warrants which sometimes circulated as cash.[5] In short, a state fund, financed by premiums collected from employers, with its reserves invested in securities, is subject to the same hazards, in time of financial crisis, as a private insurer. Only the fact that a state fund, if it becomes insolvent, can and will be bailed out by the state makes state insurance attractive from a security standpoint. The security record of private insurance carriers, while not perfect, is, nevertheless, remarkable. Since the beginning of workmen's compensation in the United States the total of the defaults by insolvent private insurance carriers on their workmen's compensation obligations is only a small fraction of one per cent of such obligations. Admittedly even that amount, relatively small though it is, is too much. The remedy, however, is not state insurance. An examination of the record will show that almost every casualty company, stock or mutual, placed in liquidation by a state insurance department, had a surplus to policyholders so small that it is at least doubtful that it should ever have been licensed by any state to write workmen's compensation coverage.[6] A free enterprise system should encourage the formation of new insurance companies. Further, a state's insurance laws should not limit the field of insurance to persons or organizations with millions of dollars of capital seeking employment. Nevertheless, every state has the right and the duty to require that a casualty insurance company seeking to write workmen's compensation coverage have a surplus to policyholders adequate to insure that in time of adversity it will meet its workmen's compensation obligations. In this respect the insurance laws of many states are inadequate, particularly in view of the present inflationary tendencies of our economy.[7]

[3] KULP, CASUALTY INSURANCE 467 (rev. ed. 1942).

[4] At times the Washington and West Virginia funds have found it necessary to pay in warrants instead of cash. SOMERS & SOMERS, WORKMEN'S COMPENSATION 131 n.131 (1954). An actuarial audit of the West Virginia Fund in 1925 reflected a deficit approaching five million dollars. DODD, ADMINISTRATION OF WORKMEN'S COMPENSATION 550 (1936).

[5] See N.Y. Times, Feb. 11, 1932, p. 29, col. 7; *id.*, Feb. 27, 1932, p. 23, col 7; id., Aug. 2, 1932 p. 21, col. 6. The present difficulties of the State of Michigan in meeting some of its financial obligations may also be worth mention.

[6] See, *e.g.*, BEST'S INSURANCE REPORTS—FIRE AND CASUALTY 698b-707b (1958). The reference here cited is to a list of insurance companies which have been retired within the last ten years. A similar list has appeared in every issue for many years.

[7] *E.g.*, minimum surplus requirements to write workmen's compensation insurance in Colorado is $50,000. COLO. REV. STAT. ANN. § 72-1-36 (1953); Illinois, $100,000. ILL. ANN. STAT. ch. 73, § 625 (Smith-Hurd 1940); Kansas, $50,000. KAN. GEN.

In New York the private carriers' security problem has been met by the creation by statute of two security funds, one to secure the obligations of insolvent stock companies, the other the obligations of insolvent mutual companies. At the close of 1957 the total assets of these two funds exceeded $20,800,000. Pennsylvania has two similar funds, also established by statute. Other states have statutes the effect of which is to pool the credit of all workmen's compensation carriers to secure the compensation liabilities of insolvent carriers.[8] These devises emphasize the point that it lies within the power of state legislatures to make the security offered by private insurance as sound as the security afforded by state funds is claimed to be.

The oft-made statement that without state insurance small employers or employers engaged in hazardous work find it difficult and sometimes impossible to get compensation insurance is without foundation in fact. In thirty of the thirty-one states which have no form of state insurance, and in the District of Columbia and Hawaii, any employer whose application for compensation insurance has been refused by several carriers, usually three, can get insurance immediately, by payment of an advance premium computed at manual rates approved by the state insurance department, from an assigned risk pool operated by private carriers. As yet there is no assigned risk plan in operation in Alaska. An assigned risk plan, however operated, has a two-fold purpose. First, it distributes equitably among all carriers writing compensation insurance in a particular state losses from so-called "undesirable risks." Second, and more important, it makes certain that every employer subject to that state's compensation law can buy insurance. Some pools are statutory, some voluntary. The creation of every assigned risk plan, statutory or voluntary, was brought about by the initiative of private carriers.

The primary purpose of the weekly benefits prescribed by a workmen's compensation law is to replace wages lost by the disability or death of an injured worker. Because the average worker never accumulates savings sufficient to care for himself and his family when his wages are cut off, the prompt payment of benefits due because of a work injury is vital to an injured worker and his family. It follows that one of the prime objectives of the administration of every workmen's compensation law should be the payment of benefits when they are due. The responsibility to see that this objective is carried out rests with workmen's compensation administrators, employers and insurance carriers, state or private. The true test of accomplishment with respect to the prompt payment of compensation, after an accident causing disability, is not the number of days after receipt of an accident report that payment is made, but rather whether the first payment is made on or before the date the compensation law says it is due. To get a compensation check in the hands of an injured claimant on the due date, the first requirement is that the employer report the injury or disease promptly to his carrier. Upon receipt of the report, the carrier must process the claim for payment. Such statistics as are available indicate that private carriers almost uniformly excel state funds in starting the payment of compensation in disability cases. See Schedule A at the conclusion of this article.

The figures shown in Schedule A deserve some comment. In Wisconsin, Michigan and New York more than 80 per cent of first payments are made when due. Massachusetts approaches that figure. In each of these four states the industrial accident commission has made the prompt payment of compensation one of the prime objectives of the administration of the compensation law. The carriers, state and private, have cooperated, and in particular have educated employers to report promptly every case of work injury. The result secured is an impressive illustration of what can be accomplished by cooperation between the administrative authority, insurance carriers and employers. Wisconsin's outstanding record is noteworthy because all compensation insurance in Wisconsin is written by private carriers. In short, under any compensation law it is the responsibility of the board,[9] carriers and employers to see to it that compensation is paid when due. In

[8] See, for instances, MINN. STAT. ANN. §§ 79.28-.32 (1949).

STAT. ANN. § 40-1103 (1949); Mississippi, $100,000. MISS. CODE ANN. § 5660 (a) (4) (1942); New Hampshire, $50,000. N.H. REV. STAT. ANN. §§ 401.4, 402.13 (1955); Texas, $75,000 .TEX. REV. CIV. STAT. ANN. art. 2.02 (4) (Supp. 1958).

[9] The word "board" will be used throughout to designate the public agency charged with the administration of a workmen's compensation law.

this respect the record of private carriers excels that of state funds.[10]

From the beginning of our compensation system the cost of medical care required for work injuries has been approximately one-third of the loss portion of the premium dollar. To illustrate, of the $684 million compensation losses incurred in 1957 by private carriers reporting to the National Council on Compensation Insurance, approximately $228 million represents medical costs. This money was spent to cure and relieve workers of the effects of their injuries and to restore them to work ability. Obviously in a case of serious injury skilled medical care is not only best from the worker's standpoint, but is the cheapest from the insurer's. The sooner the worker is cured and back at work, the less the case will cost. One is inclined, therefore, to jump to the conclusion that medical care of injured workers presents no problem and that every worker will automatically receive good care. Unfortunately that is not the case. Even today, with our compensation system approaching its golden anniversary, many injured workers do not receive the degree of medical care which is necessary to restore promptly their work ability and which it is in the interests of insurance carriers, public or private, that they get. An overall discussion of the compensation medical problem is outside the scope of this article. Our question is whether an injured worker will get better medical care under monopolistic state insurance or under a system which permits private insurance.

First, seventeen of our states limit radically the dollar amount or the time within which medical benefits are payable. For a summary of these limitations, see Schedule B at the conclusion of this article. In the light of today's medical costs every one of these limitations is unrealistic. Of these seventeen states, one has a monopolistic and four, competing funds; the remaining twelve, private insurance. Of the four competing funds, one is Arizona's which writes well over half of the compensation premiums developed in the state. Certainly workers in West Virginia and Pennsylvania do not get adequate medical benefits. It is a matter of public record that the United Mine Workers, through a fund maintained by contributions required of the operators by labor contracts, maintains hospitals and furnishes medical treatment to union members seriously injured at work in West Virginia and other states whose compensation laws provide only limited medical benefits. On the other hand, the laws of all of the heavily industrialized states, except Pennsylvania's, provide unlimited medical care for injured workers. Of these states only Ohio has a monopolistic fund. This record does not support a case for state insurance, but rather the contrary.

The fact is that whether an injured worker gets skilled, adequate medical treatment depends on the provisions and administration of the applicable compensation law. Theoretically it should make no difference, in a particular case, whether the insurer is a state fund or a private carrier. Actually, the private carrier, which seeks a profit and must break even to keep going, has a stronger motive than a state fund to get an injured worker back on his job. The medical provisions of our compensation laws form a crazy patchwork. some give the employer or insurer the unrestricted right to select the physician to treat an injured worker. Other laws limit the selection to physicians named in a "panel" of doctors, usually approved by administrative authority. Still other laws give an injured worker unlimited free choice of physicians. In no state does the law and its administration afford a worker or an insurer, if it appears that the treatment being given in a case of serious injury is ineffective, a sure, speedy remedy by which the care of the injured worker can be shifted to another physician or perhaps to another hospital. In short, what is necessary is the amendment of the medical benefit provisions of most of our compensation laws. First, such benefits should not be limited, either by time or amount. Second, each such law should contain such provisions as are necessary, under proper administration, to make certain that every seriously injured worker receives skilled medical and hospital care.

### Rehabilitation

Section 10 of the Federal Vocational Rehabilitation Act defines the science of rehabilitation as "any service necessary to render a disabled individual fit to engage in a remunerative occupation." Obviously rehabilitation is applicable to a field much broader than workmen's compensation. Today the rehabilitation of the victims of au-

[10]The California State Fund has an outstanding record for payment of compensation when due; New York's record is excellent, but available records indicate the leading private carriers do better.

tomobile accidents presents a problem more serious than that of persons injured at work. The same is true of the rehabilitation of persons suffering from congential defects, from nervous disorders, and from degenerative diseases common to middle and late middle life. Nevertheless, the necessity of rehabilitating the victims of work injuries has been recognized in practice almost from the beginning of our compensation system, first by private insurers, second by competing state funds and last by exclusive funds. Not one of the early state compensation laws contained a provision concerning rehabilitation. Nevertheless, the provisions of each such law impelled an insurer, particularly a private insurer, to recognize the necessity of getting a seriously injured man back to work, or, in other words, to rehabilitate him. Early methods were crude and, in fact, consisted mostly in persuading an employer to put back to work a man who had suffered a serious permanent injury, if not on his old job then on work which he could do. It was soon recognized, however, that such methods were inadequate and that a broader program was necessary.

Admittedly progress was slow, but private insurance sparked it. Before 1930 the Aetna Casualty and Surety Company, then and now a leading compensation carrier, established the first clinic used exclusively for the physical restoration of injured workers. Its accomplishments and the results secured by other insurance companies that used it as a pattern for their rehabilitation efforts came to the attention of state legislatures and played a part in bringing about the ammendments of several compensation laws to include provisions for rehabilitation of injured workers. Private carriers are still setting the pace in rehabilitation. Most carriers use private or public facilities available to them, such as the Kessler Institute for Rehabilitation, in West Orange, New Jersey, and the Institute of Physical Medicine and Rehabilitation at New York University-Bellevue Medical Center, the latter under the direction of Dr. Howard A. Rusk, a tireless crusader for rehabilitation, and the vocational rehabilitation facilities of the several states. Liberty Mutual Insurance Company probably the leader among private carriers, maintains two rehabilitation centers, one in Boston and one in Chicago. Over the past sixteen years these two centers have treated and trained more than five thousand severely injured persons, of whom more than 75 per cent have returned to independent productive life. As of 1951 the average time lag between date of injury and the beginning of treatment at the Liberty Mutual clinics was six and a half months against seven years for the average time lag in cases referred to a rehabilitation center by a Board, a difference of immense importance in its bearing on the success of rehabilitation treatment.[11] Liberty Mutual reports that at the end of 1957 this time lag had been cut to six months.

That state insurance, even a monopolistic fund, does not of itself bring about rehabilitation of injured workers is established by the experience in Ohio. From 1933 to 1938 there was an annual average of less than 100 cases referred to the Ohio Bureau of Industrial Rehabilitation.[12] In 1944 the Bureau published a plan providing for expansion of its work. However, as recently as 1952 Mr. Jacob Clayman, secretary of Ohio's CIO Council, testified as follows:

> One of the problems which greatly concern us in the field of health is the rehabilitation of industrially injured workers. The plain fact is that of this moment we in Ohio have pitifully inadequate facilities to bring aid and succor to the armless, the legless, the worker with an injured spine, and all the usual severe industrial injuries which can and do befall the Ohio worker.
>
> In Ohio the handicapped worker is pretty much left to his own devices and his own fate. He can receive the weekly workmen's compensation pittance allowed by law but beyond that he takes the hazards of the future strickly on his own.
>
> The plain fact is that while there is much talk about rehabilitation in Ohio there is virtually none in operation.
>
> For example, in 1949 the great State of Ohio spent $204,881 on vocational rehabilitation. This pitiful sum to be used to provide rehabilitation is like draining the sea with a thimble.
>
> To digress, the last time I checked, we had 103 people serving as full-time game wardens. We spent more money in

[11] U.S. Office of Defense Mobilization, Task Force on the Handicapped, *Report to the Chairman, Manpower Policy Committee* 37 (1952).

[12] LANG, WORKMEN'S COMPENSATION INSURANCE 98 (1947).

attempting to rehabilitate and preserve animal life in Ohio than we spent on the whole desperate human problem and economic problem of rehabilitation of workers.[13]

Since the delivery of this statement, there has been established at Ohio State University a rehabilitation center where sixty-one patients were treated in 1955 (against 900 patients treated in corresponding centers in Wisconsin, the state reporting the largest number).[14] Beyond doubt, the number has grown in the past three years. On the evidence, however, one is entitled to doubt that the largest exclusive-fund state has benefited its industrially disabled citizens, over the last generation, by barring to them the rehabilitation services of private insurers.

At the same time it must be recorded that several state funds have followed the example set them by private carriers in rehabilitation work. The New York fund "as of October 1957 had referred some 515 cases to various agencies and centers for rehabilitation services; of these 319 developed into cases of actual rehabilitation."[15]
The monopolistic fund states of Oregon and Washington each maintains its own well-equipped, well-operated rehabilitation center. The author does not have available precise information on the results secured at these centers, but such information as is available indicates both are doing outstanding work. The California State fund, in cooperation with the State Bureau of Vocational Rehabilitation, also has an aggressive rehabilitation program and some notable achievements to its credit. In short, a sound rehabilitation program is possible, and necessary, under state insurance or private insurance.

There are two gains to society when a seriously injured person is restored to work ability. First, the cost of compensation insurance is reduced. More important, society has a productive worker instead of a non-productive consumer. When an apparently totally disabled person drawing $40 a week compensation is returned to work at a wage of $60, the net gain may be roughly measured at $100. Actually it is more, to say nothing of the restoration of human values accomplished by making a man again a useful member of society. Why, then, is the overall program of rehabilitation of injured workers, and of other disabled persons, so far behind the country's actual needs? Only thirteen states provide maintenance during vocational rehabilitation. Only fifteen states have positive provisions for rehabilitation in their compensation laws. Only seven workmen's compensation laws place on the board responsibility to see that every seriously injured worker gets such physical restoration services as he needs and vocational rehabilitation when necessary. Our shortcomings in rehabilitation are due largely to defects in our statutes and in administrative procedures.

The first step in the rehabilitation of an injured worker who has lost an arm or a leg or has suffered a fractured spine is to convince him that someday he is going back to work. This can be best accomplished by a trained rehabilitation counselor or nurse who should call on the injured man as soon as his condition permits. Where necessary, the counselor secures the cooperation of the injured person's wife or other members of his family. As soon as the patient's condition permits, physical restoration treatment should be started. In an amputation case, a properly designed prosthesis must be fitted and the patient taught to use it. Finally, if his injury precludes the patient from returning to his former occupation, he must be trained for other work.

Every compensation law should contain provisions to make certain these procedures are carried out as soon as is consistent with the welfare of the patient. Every law should provide maintenance during vocational rehabilitation. Further, it might not be amiss for every board to charge one of its officials with the responsibility of following every case of serious permanent injury, to see to it, by advising the claimant and consulting with the carrier and attending physician, that the claimant receives whatever physical restoration treatment or

[13]Clayman, quoted in 5 BUILDING AMERICA'S HEALTH: A REPORT TO THE PRESIDENT BY THE PRESIDENT'S COMMITTEE ON HEALTH NEEDS OF THE NATION 14, 15 (1953).

[14]192 BUREAU LABOR STANDARDS BULL. 221 (1957).

[15]Raymond J. Oakley, Secretary, The American Association of State Compensation Insurance Funds, *Presentation Before the Alaskan Legislative Council* (January 6, 1958).

In his presentation Mr. Oakley also stated that of 342 referrals in 1955 by all carriers to the State Division of Vocational Rehabilitation, the State Fund made 228, and inferred that these figures indicated that private carriers and self-insurers were neglecting rehabilitation. The fact is that many private carriers and self-insurers make little use of the Division, but rather rely on other agencies, their own counseling services and on employers for vocational rehabilitation.

vocational training may be necessary. It is not necessary to socialize our workmen's compensation system to get a sound rehabilitation program. What is necessary are sound statutes, soundly administered. The records of the Liberty Mutual Insurance Company, Employers Mutual Liability Insurance Company and other insurers establish that private insurers can do a rehabilitation job as well as or better than a state insurance fund.

### Accident Prevention

In the early 1900's concern over the great number of industrial accidents was not confined to those who believe workers should be protected by workmen's compensation laws. The long-accepted notion that industrial accidents were a part of the price of progress was being challenged by many persons who contended that work injuries could and should in large measure be prevented. Their arguments carried weight with the commissions and legislative committees who framed our early compensation laws. The titles of the California and Massachusetts statutes each included language indicating one of its purposes was the prevention of work injuries. The framers of the Massachusetts Act regarded as the most important aspect of the law its potential for reducing the number of industrial accidents.[16] To achieve that objective they believed the organization of insurance under the act should be in the hands of the employers themselves, its operating expenses should not be paid from public funds, and the credit of the state should not support it. Of state insurance they remarked:

> The institution of such a practice would defeat the very object for which the association was created; that is, to secure the active, intelligent, and interested attention of employers upon the problems of compensation insurance and prevention of accidents.[17]

That most states followed the course set by Massachusetts in requiring that security for payment of compensation be provided by private insurance must be given weight in the reader's consideration of the respective merits of private and state insurance.

Immediately after the passage of the first workmen's compensation laws private insurance carriers undertook the task of industrial accident prevention. The first person hired by the directors of the Massachusetts Employees' Insurance Association[18] was a distinguished safety engineer. In 1910, with the passage of the first New York workmen's compensation law, twenty leading stock companies formed the Workmen's Compensation Service Bureau for the prevention of industrial accidents through statistical studies, the establishment of safety standards and by working with employers and other interested organizations, such as the National Safety Council, for the cause of industrial safety. The Bureau, continuously in existence since 1910, is now the accident prevention division of the Association of Casualty and Surety Companies. The American Mutual Insurance Alliance maintains a similar facility.

Workmen's compensation carriers, stock and mutual, formed their own accident prevention departments. Systematic inspection of plants by insurance company engineers and improvement of safety standards by recommendations supported by "follow-ups" had become standard as early as 1913.[19] Private insurance safety work follows three main courses—(1) inspection and consultive services for employers, (2) research into accident causes, work procedures and occupational disease hazards, and (3) cooperation with other private agencies working for industrial safety, such as the National Safety Council and the American Standards Association, and with state labor departments and other public bodies. The larger private carriers maintain their own research laboratories; other companies make use of insurance association or other private research facilities. The cost of this safety work is approximately 2 per cent of the compensation premiums collected annually by private carriers.[20]

The measures taken by private insurance carriers to deal with the hazards created by the development of nuclear energy the last fifteen years graphically illustrate their continuing interest in industrial safety. A few of the larger carriers have been active in the nuclear energy field since 1942 and in

[16] Massachusetts Commission on Compensation for Industrial Accidents Report 46 (1912).

[17] Massachusetts Commission on Compensation for Industrial Accidents Report 53 (1912).

[18] Now the Liberty Mutual Insurance Company, the largest workmen's compensation insurance carrier in the United States.

[19] Massachusetts Industrial Accident Board Annual Report 140-225 (1914).

[20] National Council on Compensation Insurance Annual Report (1957).

safety work on radiation hazards for a longer period. With the passage of the Atomic Energy Act of 1954, which ended, as a practical matter, the government monopoly of nuclear energy, both the stock and mutual companies formed nuclear energy engineering committees whose function is the protection of workers and the public from injury from the hazards created by the use of nuclear energy The members of these committees are trained health and nuclear physicists. The committees cooperate with each other, with the National Safety Council, with the National Committee on Radiation Protection,[21] with the Atomic Energy Commission, and with interested state agencies. Representatives of the two committees have inspected and will continue to inspect every private plant in the United States which has a substantial nuclear energy hazard and which carries private insurance, physical damage, general liability or compensation. With respect to protection of workers, such an inspection includes checking radiation exposures to make certain they are within safe limits, checking for presence in the air and elsewhere of toxic substances, checking the condition of machines and equipment, and safety and working procedures. Dangerous conditions or procedures are called to the attention of the employer, and the inspectors work with the employer to remove them. These organizations, set up by private insurers, will be a bulwark of protection for workers in plants employing nuclear energy.

Some of the state funds, particularly the competing funds in California and New York, give their insured employers excellent accident prevention service. Of the monopolistic funds, Oregon has an aggressive safety program in cooperation with the state labor commissioner. Recently the Washington and Ohio funds have stepped up their accident prevention work. At the other extreme, the West Virginia fund reports no money spent for safety work. Because of different premium bases, different accounting methods and differing conditions from state to state, it is difficult, if not impossible, to compare accurately the actual performance of the safety work done by private carriers and state funds. What figures are available tend to indicate that private carriers spend relatively more money than state funds for safety work. The four competing funds[22] reporting to the National Council on Compensation Insurance had in 1957 net earned premiums of $114,095,261.00, and inspection expenses of $1,487,753.00, or a little less than 1.4 per cent of earned premiums.[23] The California fund reports spending approximately 1.6 per cent of earned premiums; Pennsylvania's, 5.4 per cent; and Michigan's, less than 1.0 per cent. Because some competing state funds write many risks at less than manual premiums, the above percentages would be reduced if all state fund premiums were adjusted to the manual premiums private insurers would have charged for state fund risks. It appears, therefore, that private carriers spent relatively more money for loss prevention than competing state funds.

The relative performance of monopolistic funds is difficult to determine. The amount spent for accident and disease prevention by the Ohio fund increased from $488,342 in 1952 to $805,259 in 1956. In the five years ending with 1956 Oregon spent for accident prevention approximately 3.1 per cent of premiums received. Adjustment of these figures to the basis on which private insurance is written would put the percentage below 2.0 per cent. Washington spends less than 2.0 per cent of its premium for safety work. West Virginia spends nothing. Overall, these figures lead to the conclusion that monopolistic funds spend less money on loss prevention than would private insurers were they writing the business.

In the last fifty years there has been a notable reduction not only in the incidence but, in most states, in the number of serious industrial injuries. This result has been achieved through the efforts of labor, employers, private insurers, private safety organizations, and state and federal labor departments. It should not go unnoticed that Ohio, with a monopolistic fund, has by far the poorest record in this respect of any heavily industrialized state. An analysis of Schedule C at the end of this article will show that the average annual number of fatal injuries per 100,000 workers has decreased for the twenty-five years ending in 1952 less in Ohio than in the other five states listed, and that Ohio's accident rate per 1000 employees has decreased not at all. *Post hoc* is not *propter*

[21]The National Committee on Radiation Protection, established by the American Standards Association, has been working for nearly thirty years on the problems of protecting workers and the public from radiation injury.

[22]California, Michigan, New York and Pennsylvania.

[23]National Council on Compensation Insurance, Insurance Expense Exhibit (1958).

*hoc;* it may be that the exclusion of private insurers and their accident prevention work from Ohio had nothing to do with Ohio's poor safety record. However, the reader may well reach a different conclusion.

### Adequacy of Benefits

The argument that the compensation laws of states with monopolistic funds give workers benefits more liberal than those given by other states does not stand examination. Rather it appears from the information available that the presence or absence of state insurance has no effect on the schedule of benefits provided by a state's compensation law. One of the best measures of the adequacy of a state's compensation law is the ratio of the maximum weekly temporary total disability benefits given by the law to the average weekly wages earned by that state's workers. Schedule D shows the standing of every state in this respect. Of the industrial states, Massachusetts heads the list with a ratio of 66.9. Oregon and Washington, monopolistic fund states, have ratios of 57.6 and 55.7 respectively. Ohio and West Virginia, also with monopolistic funds, with ratios of 43.7 and 38.7 are close to the rear of the procession. Examination of other yardsticks, such as the maximum amount payable and the period during which benefits are payable in death cases and in cases of temporary or permanent total disability, supports the conclusion that state insurance does not result in more liberal benefits for injured workers.

### Insurance Cost

A rational comparison of the cost of state insurance and of private insurance is impossible. First, because of the differences between the premium bases and the accounting procedures of state funds, particularly monopolistic funds, and of private insurers, a comparative anlaysis of costs and expenses of the two groups is difficult. Second, and probably more important, private insurers give employers services not available from state funds and in general give more coverage than state funds. It follows that comparing the two types of carriers, particularly their expenses, is akin to comparing a three-ton and a five-ton truck. The question is not which one is the better, but rather which model is needed to do the job. Let us, however, examine the reported premiums, losses and expenses of state funds and private carriers. In this analysis, monopolistic and competing state funds, because of differences in their methods of operation and reported expenses, will be treated separately.

Schedules E, F, G. H, and I, at the end of this article, show the loss and expense ratios, for the years 1949 to 1957, of all types of private carriers and of the four competing state funds reporting to the National Council on Compensation Insurance, the loss and expense ratios of the New York State fund from 1953 to 1957 and of the California fund from 1952 to 1956, and the loss and expense ratios of the larger monopolistic funds. The following principles should be kept in mind by one examining these schedules, although each is subject to some qualifications which lack of space makes it impossible to spell out here. Competing state funds, and particularly the larger funds, are usually self-supporting and get no money from their state governments. Next, in some respects competing funds provide insured employers with services comparable to those given by private insurers. Competing state funds usually pay the same premium taxes as private insurers, but are exempt from federal income taxes and in some cases from local taxes on owned real estate. Monopolistic funds pay no direct taxes, premium or otherwise. Because monopolistic funds rely to a considerable extent upon employers, claimants and physicians to furnish information necessary for processing claims, their administrative expenses are lower than those of competing state funds. Some monopolistic funds, such as Oregon and West Virginia, are self-sustaining. Others, such as Ohio and Washington, defray part of their expenses from money appropriated to their use by the states. The foregoing facts make clear the difficulty of comparing state with private insurance, as well as of comparing one state fund with another.[24]

It is clear from the schedules that the cost of compensation insurance sold by the states is less than the cost of similar insurance sold by private carriers. This difference in overall cost is due mainly to the lower operating expenses of state funds. The reason for these savings are in the main clear. The operating expenses of the four funds reporting to the National Council (Schedule E), with acquisition costs deducted, were 21.5 per cent of earned premiums for 1957. Because competing funds often

[24]The information in this paragraph concerning state funds was secured directly from an official of each fund specifically.

sell business at rates less than those charged by private carriers, this 21.5 figure is redundant in comparison with private carrier expenses and should be reduced to 17.5 or 18.0 per cent. For 1957 the comparable figures for non-participating private carriers was 21.0 per cent; for participating stock carriers, 16.4 per cent; and for mutual carriers, 18.1 per cent. These figures, including as they do the two largest competing funds, California and New York, indicate, if, indeed, they do not establish, that state insurance, subject to the same taxes and giving the coverages and services comparable to those afforded by private insurance, has little if any cost advantage aside from those costs termed "acquisition expense." This subject will be discussed later.

There is no sound reason why a monopolistic fund, giving the same coverage and services as well-managed competing fund, should have an expense ratio much less than the competing fund's. The monopolistic funds only advantage, if all expenses are paid from the fund, should be its exemption from all direct taxes. Nevertheless, the monopolistic fund's reported expense ratios range from Oregon's high of 9.5 per cent to Ohio's low of 5 per cent. The reason for this difference is explained largely by the fact that monopolistic funds do not give the same services to claimants and employers as competing funds and private insurers. For instance, in Oregon or Ohio the board does not process a case until the injured worker has filed claim. For a seriously injured worker or for one ignorant of his rights, this procedure, thrifty though it may be, imposes a serious handicap on the claimant. In Ohio compensation payments are not started until the employer certifies that benefits are payable. Hence, the employer has the responsibility of the completion of whatever investigation is necessary.[18] In a non-monopolistic fund state, any insurance carrier, on receipt of an accident report, is under a duty to make a prompt investigation and, if compensation is due, to start payment promptly. To give that service an insurer must maintain a claims department staffed with competent supervisors and investigators. That monopolistic funds do not give employers the services they need in workmen's compensation matters is borne out by the many service organizations which flourish in those states. Such bureaus have existed in Ohio since 1921. In 1946 there were twenty-five such bureaus, giving employers actuarial, claim or loss prevention services. The charge for such services is said to average around 10 per cent of an employer's workmen's compensation premiums. In West Virginia, for the year ending June 30, 1944, twenty-three coal mining companies, representing 25.3 per cent of the premiums paid to the West Virginia fund by employers classified as "Coal Mining," paid 12 per cent of their compensation premiums for services ordinarily given by workmen's compensation carriers. In Washington, in 1945, there were six bureaus giving employers services ordinarily given employers by private carriers, particularly with respect to claims and loss prevention. Their charges ranged from 5 to 7 per cent of an employer's premium to the state fund. The fact is that it costs money to administer a workmen's compensation law. What costs are not paid from premiums must come from some other source, state subsidies or employers, or even employees.[19]

Finally, the most important objective of a workmen's compensation law is to protect the income of workers and their families. Keeping administrative costs low may defeat in part this objective. On this point, Marshall Dawson commented as follows:

> What the workman receives and what the administration costs are two diffrent things. What he receives is provided in the workmen's compensation act of his State . . . strange as it may seem, in one state the workman may get 90 per cent of the dollar the employer pays for insurance and still receive less than is paid the workman in an adjoining State where the injured man is said to receive only "52 per cent or less" of the amount paid as insurance premiums. The benefits actually paid to the workman depend upon the standard of liberality set by the state workmen's compensation law and the interpretation of the law.
>
> Whenever low administrative cost is considered, as a desirable goal for labor, the factor of "service" must be scientifically scrutinized. If this is not done, the worker may lose instead of gain by the cheapening of the administration of the

[18]For a comprehensive discussion of Ohio workmen's compensation procedures and the work required of claimants and employees, see Beall & Beall, *The procedure and Practice*, 19 OHIO ST. L.J. 591 (1958).

[19]The statements made in this paragraph are based on research made by Mr. Frank Lang. LANG, WORKMEN'S COMPENSATION INSURANCE 194-202 (1947).

workmen's compensation act.[27]

Private insurance costs more than state insurance because private insurers give more coverage than, and afford services not available from, state funds generally, particularly monopolistic funds. Whether the additional coverage and services are worth the difference in cost is still the subject of vigorous argument, pro and con. The proponents of state insurance cannot escape the fact that when given the opportunity to choose between state and private insurance the great majority of employers take private insurance. In these days of fierce competition, when an employer, in the face of the fact that he can save 10 or 15 per cent of his compensation premium by placing his insurance with a competing state fund, gives it to a private insurer, he does so because he is satisfied that what he gets is worth what he pays. Let us, therefore, examine briefly the protection and services given employers by private insurers.

The standard workmen's compensation and employers' liability policy used throughout the United States by all but a few private insurers gives complete protection against an employer's liability to his employees under the compensation law of each state listed in the policy. The policy also gives employers' liability coverage for injuries to employees injured in operations in each such state, including coverage for the insured's liability to a third party for damages because of suits brought against such third party by an employee of the insured because of bodily injury arising out of and in the course of his employment by the insured.[28] Employers' liability coverage gives an employer protection against liability for injury by disease sustained by an employee in his employment and not compensable under any workmen's compensation law. The insurer is obligated to defend employers' liability suits without expense to the insured. The California and New York funds afford equivalent employers' liability coverage, but most state fund policies give no employers' liability coverage at all. Further, an employer with multi-state operations can get, from a private insurer, under one policy, compensation and employers' liability insurance under the laws of every state which permits private insurance.

An employer whose operations are not limited to particular states can get from a private insurer "all states" coverage[29] which indemnifies him against loss on account of bodily injury sustained by one of his employees and to which none of the compensation laws listed in his policies is applicable. For employees not protected by any compensation law, as workers subject to the Federal Employers Liability Act, members of the crews of vessels and, in some states, executive officers of corporations, an employer can get voluntary compensation coverage. Each coverage—all states and voluntary compensation—is given by an endorsement forming a part of an employer's workmen's compensation and employers' liability policy. Finally, it is not unusual for an employer to agree, by contract with the union representing his employees, to pay employees injured at work benefits in excess of those provided by the applicable compensation law. Such a liability can be insured with the employer's private insurance carrier. No state fund can match the workmen's compensation and employers' liability coverages available to employers from private carriers.

Next, an employer gets from private insurance, either through an agent or broker or through a representative of a direct dealing company, an information and consulting service which most state funds, particularly the exclusive funds, do not provide. A businessman wishes to know something about his state's compensation law, his liability thereunder, the protection it gives him from suits by his employees, why his premium rates went up this year, how his experience or retrospective rating plan works, whether he should buy compensation coverage in another state where he temporarily has some employees working. His insurer's service representative or agent answers his questions, makes certain he has proper coverage, and otherwise takes care of his compensation insurance needs. In addition, the service man or agent, whose very existence state fund proponents say is needless, delivers the insured his policy, collects the premium, and sometimes extends his personal credit to a good client short of cash. In short, the services, charged

[27] U.S. BUREAU OF LABOR STATISTICS, DEP'T OF LABOR, BULL. No. 672, DAWSON, PROBLEMS OF WORKMEN'S COMPENSATION ADMINISTRATION IN THE UNITED STATES AND CANADA 153 (1940).

[28] *E.g.*, Ryan Stevedoring Co. v. Pan-Atlantic Steamship Corp., 350 U.S. 124 (1956); States S.S. Co. v. Rothschild Int'l Stevedoring Co., 205 F.2d 253 (1953); Westchester Lighting Co. v. Westchester County Small Estates Corp., 278 N.Y. 175, 15 N.E.2d 567 (1938).

[29] Not available with respect to monopolistic fund states.

by private companies to acquisition expense, in 1956, for stock companies 15 per cent and for mutuals 7.3 per cent of premiums written,[20] are necessary. There is little or no net saving to society or to insurance buyers because monopolistic funds do not give the services afforded by private carriers. An Ohio employer either has some of his employees do the work or engages one of Ohio's service bureaus. That the competing funds, within their circumscribed areas, give services approaching those given by private insurers is perhaps due to the competition.

Proponents of state insurance, compensation and other, claim that expenses of private insurers are excessive and to a considerable extent unnecessary. Some go so far as to urge that the premiums paid should be no more than is necessary to cover losses. The plain fact is that no organization, public or private, can conduct an insurance business without expense. That expense includes taxes, the cost of the insurer's own administration and the cost of service given insureds and claimants. The more service an insurer gives, the greater its expense ratio. Were Texas to replace next year its present system of private insurance for workmen's compensation with an exclusive fund, it is doubtful that the overall expense of the compensation system would be materially reduced. The state's present income from premium taxes would have to be made up by other levies. To the extent that the apparent cost of insurance might be reduced by the state fund's not giving claims, underwriting, actuarial or loss prevention services, Texas employers would, if experience in other states is any criterion, get those services, at their own expense, from other sources. The foregoing is not to say that the present expense ratios of private insurers are sacrosanct. On the contrary, the insurers are making and should continue efforts to reduce expenses and state regulatory authorities and employers should not only cooperate in those efforts but should see to it that they are continued.

## Conclusion

From the foregoing discussion one basic issue emerges—which institution, state insurance or private insurance, is better fitted to achieve the purposes of the workmen's compensation system? Experience in the seven monopolistic fund states proves that a monopolistic fund does not give the protection or services afforded by competing funds and private insurers. Such a result, it may be noted in passing, seems one of the inevitable results of monopoly in any form. As between competing funds and private insurance, it appears that on balance private insurance should get the nod, perhaps with a word of warning that its performance must continue to improve. That private insurers give broader coverage and better service than competing funds has been demonstrated above and moreover the verdict has been given by private employers in the eleven competing fund states. In those states, in 1955, private insurers paid 61.6 per cent and competing state funds 22.5 per cent of the $354,647,000 disbursed in compensation payments.[21] Cost conscious American business prefers private insurance because the broader coverages and better services it gives make private insurance worth what it costs. More important, there is no evidence that under a system of state insurance an injured worker gets a better deal. True, under state insurance a larger proportion of the premiums paid by employers goes for compensation benefits, indemnity and medical. Those benefits in monopolistic fund states, however, are no larger than, if as generous as, the benefits in other states. To illustrate, the benefits paid in Ohio and West Virginia compare unfavorably with those paid in Massachusetts and Wisconsin, where there is no state insurance, or with those paid in New York and California, where state funds compete with private insurance. Overall an injured worker gets better service under a system of private insurance. He does not have to give notice or file claim unless his employer has failed to report his injury or liability is contested. In most work injury cases, because liability is clear, private carriers start payments promptly. In short, it is a ten-to-one bet that if the workers in monopolistic fund states were familiar with the compensation systems of Massachusetts, New York, Wisconsin, California and other states permitting private insurance, they would themselves demand the end of state insurance. Private insurance rests its case on the proposition that, given a sound workmen's compensation law, soundly administered, it can do a better job than state insurance for both employers and workers.

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[20] Best, Fire and Casualty Aggregates Averages 122, 190 (1957).

[21] 19 Social Security Bull. No. 12, p. 18 (Dec. 1956).

## SCHEDULE A

### PROMPTNESS OF WORKMEN'S COMPENSATION PAYMENTS

| New York | Per Cent of Cases in Which First Payment Was Made Within 18 Days After Disability* | | |
|---|---|---|---|
| | July - Dec. '53 | Jan. - June '54 | July - Dec. '54 |
| All Carriers | 82.6 | 82.6 | 84.9 |

| Massachusetts | Per Cent of Cases in Which First Payment Was Made Within 14 Days After Disability | | | | | |
|---|---|---|---|---|---|---|
| | Mar. '58 | Apr. '58 | May '58 | June '58 | July '58 | Aug. '58 |
| All Carriers | 67 | 72 | 69 | 72 | 69 | 73 |

| Michigan | Per Cent of Cases in Which First Payment Was Made Within 14 Days After Disability | | | | | |
|---|---|---|---|---|---|---|
| | Oct. '55-Mar. '56 | Apr. Sept. '56 | Oct. '56-Mar. '57 | Apr.-Sept. '57 | Oct. '57-Mar. '58 | Apr.-Sept. '58 |
| All Carriers | 83.4 | 84.8 | 80.9 | 82.0 | 80.2 | 86.7 |
| Self-Insurers | 78.0 | 80.3 | 77.7 | 78.6 | 80.9 | 80.2 |
| State Fund | 37.5 | 52.6 | 44.5 | 53.8 | 55.1 | 57.4 |

| Wisconsin | Per Cent of Cases in Which First Payment Was Made Within 15 Days After Disability | | | | | |
|---|---|---|---|---|---|---|
| | 1953 | 1954 | 1955 | 1956 | 1957 | Jan.-June '58 |
| All Carriers | 88.7 | 89.0 | 89.8 | 89.4 | 88.5 | 88.8 |
| Self-Insurers | 83.6 | 85.1 | 84.4 | 83.8 | 82.8 | 83.7 |

*No records published for periods after 1954

Sources: New York Workmen's Compensation Board, Massachusetts Division of Industrial Accidents, Michigan Workmen's Compensation Commission, Industrial Commission of Wisconsin.

## SCHEDULE B

### JURISDICTIONS (17) WHOSE WORKMEN'S COMPENSATION LAWS PROVIDE ONLY LIMITED MEDICAL BENEFITS, INCLUDING SPECIAL LIMITATIONS FOR OCCUPATIONAL DISEASES

| Jurisdiction | Limitations | | Additional Benefit Which Board Is Authorized To Provide |
|---|---|---|---|
| | Period | Amount | |
| Alabama (a) | 6 mos. | $1,200 | |
| Alaska | 4 yrs. | — | |
| Arizona (b) | — | 1,000 | |
| Colorado (c) | — | 1,500 | |
| Georgia | 10 wks. | 1,125 | Such additional time and amount (up to $375) as will tend to lessen disability period. |
| Iowa (d) | — | 1,500 | $1,000 |
| Kansas (e) | 120 days | 2,500 | Longer period in extreme cases. |
| Kentucky | — | 2,500 | |
| Louisiana | — | 2,500 | |
| Pennsylvania (f) | 6 mos. | 450 | Such further care as will result in restoring earning power to a substantial degree. |
| South Carolina | 10 wks. | — | Such additional time as will tend to lessen period of disability. |
| South Dakota (g) | 20 wks. | 1,000 | |
| Tennessee | 1 yr. | 1,500 | |
| Utah (h) | — | 1,283.33 | $641.68 in special cases of prolonged hospitalization. |
| Vermont (i) | — | 2,500 | |
| Virginia | 60 days | — | 10 months (i.e., up to one year total period). |
| West Virginia (j) | — | 1,600 | $800 for vocational rehabilitation in exceptional cases of permanent disability. |

## SCHEDULE B—NOTES

(a) *Alabama* — covers only "occupational pneumonoconiosis" as defined.

(b) *Arizona* — medical benefits up to $1,000 are provided for *total* disability from any disease in schedule; medical benefits up to $500 are provided for partial disability from certain of the diseases in schedule. Full medical coverage is provided for traumatic injuries.

(c) *Colorado* — no compensation payable for partial disability from disease; limitation period of 6 months additionally applies in traumatic injury cases.

(d) *Iowa* — $500 for medical and surgical services; $1,000 for hospital services and supplies.

(e) *Kansas* — special medical limitation applies to silicosis.

(f) *Pennsylvania* — $450 for merical and surgical services, medicines and supplies plus hospital treatment, services, and supplies and orthopedic appliances and prostheses for six months.

(g) *South Dakota* — $300 for medical and surgical services; $700 for hospital service.

(h) *Utah* — provided only for *total* disablement from disease. Full medical provided for traumatic injuries.

(i) *Vermont* — provided only for *total* disablement from disease. Special medical limitation for silicosis.

There are twelve (12) jurisdictions whose workmen's compensation laws have special medical limitations for silicosis or asbestosis or other dust disease cases: Alabama, Arkanaas Colorado, Illinois, Kansas, Maine, Nevada, North Carolina, Ohio, Texas, Vermont, (j) *West Virginia.*

There are thirty-three (33) jurisdictions whose workmen's compensation laws provide *full medical coverage* for compensable traumatic injuries and occupational diseases (some diseases excepted; see *e.g.*, note (j) above) either by specifying full coverage (Calif., Conn., Del., Haw., Idaho, Ill., Mass., Minn., Neb., N.Y., N.D., P.R., Tex., Wash., Wis., U.S.: F.E.C.A., D.C., and L. & H.W.A.) or by authorizing Board to provide benefits or additional benefits without restriction. (Ark., Fla., Ind., Me., Md., Mich., Mo., Nev., N.H., N.J., N.M., N.C., Ohio, Okla., Ore., R.I.). Note that in Idaho and Nevada only *total* disability from disease is compensable.

## SCHEDULE C

### INDUSTRIAL FATALITIES — 25 YEAR TREND
### OHIO COMPARED WITH OTHER MAJOR INDUSTRIAL STATES

**Average Annual Number of Fatal Injuries**

| Years | Ohio | Massachusetts | New York | Illinois | Pennsylvania | Michigan |
|---|---|---|---|---|---|---|
| 1928-32 | 1,159 | 308 | 1,141 | 592 | 1,554 | 338 |
| 1933-37 | 1,001 | 218 | 823 | 453 | 1,021 | * |
| 1938-42 | 1,033 | 216 | 762 | 497 | 968 | 238 |
| 1943-47 | 1,026 | 222 | 799 | 429 | 916 | 273 |
| 1948-52 | 1,125 | 224 | 831 | 411 | 778 | 236 |
| % Change '48-'52/'28-'32 | -2.9 | -27.3 | -27.2 | -30.6 | -49.9 | -30.2 |

**Average Annual Number of Fatal Injuries per 100,000 Workers**

| Years | Ohio | Massachusetts | New York | Illinois | Pennsylvania | Michigan |
|---|---|---|---|---|---|---|
| 1928-32 | 69 | 27 | 31 | 32 | 63 | 27 |
| 1933-37 | 62 | 20 | 24 | 25 | 44 | * |
| 1938-42 | 52 | 17 | 18 | 23 | 35 | 17 |
| 1943-47 | 41 | 14 | 15 | 16 | 27 | 14 |
| 1948-52 | 41 | 13 | 15 | 14 | 22 | 11 |
| % Change '48-'52/'28-'32 | -40.6 | -51.9 | -51.6 | -56.2 | -65.1 | -59.3 |

*Michigan fatal injuries not available for 1933-1937.

Ohio fatalities are cases reported (cases compensated not available).
Other states are cases compensated.

Ohio's industrial accident rate did not decrease in the 30 years between 1917 and 1947. In 1917 the number of accidents per 1,000 persons employed was 102.5 and 109.8 in 1947. In the intervening years the rate varied from a low of 82.0 in 1921 to a high of 140.7 in 1929. In 24 years it was over 100. Figures for the years since 1947 were not available to the writer.

Sources: Annual Reports of State Industrial Commissions.

## SCHEDULE D

### RATIO OF MAXIMUM WEEKLY BENEFIT FOR TEMPORARY TOTAL DISABILITY TO AVERAGE WEEKLY WAGES BY STATE*

| State | Maximum Weekly Temporary Total Disability Benefit** | Average Weekly Wage | Ratio Maximum Weekly Temporary Total Disability Benefit to Average Weekly Wage* |
|---|---|---|---|
| Alabama | $ 31.00 | $ 69.22 | 44.8% |
| Arizona | 156.90 | 83.20 | 188.6 |
| Arkansas | 35.00 | 57.81 | 60.5 |
| California | 50.00 | 93.39 | 53.5 |
| Colorado | 36.75 | 83.43 | 44.0 |
| Connecticut | 45.00 | 88.95 | 50.6 |
| Delaware | 35.00 | 93.51 | 37.4 |
| District of Columbia | 54.00 | 80.20 | 67.3 |
| Florida | 35.00 | 71.22 | 49.1 |
| Georgia | 30.00 | 65.23 | 46.0 |
| Idaho | 41.00 | 75.26 | 54.5 |
| Illinois | 42.00 | 93.56 | 44.9 |
| Indiana | 36.00 | 88.19 | 40.8 |
| Iowa | 32.00 | 76.04 | 42.1 |
| Kansas | 34.00 | 79.29 | 42.9 |
| Kentucky | 32.00 | 74.14 | 43.2 |
| Louisiana | 35.00 | 76.53 | 45.7 |
| Maine | 35.00 | 69.37 | 50.5 |
| Maryland | 40.00 | 77.35 | 51.7 |
| Massachusetts | 52.00 | 77.75 | 66.9 |
| Michigan | 45.00 | 99.41 | 45.3 |
| Minnesota | 45.00 | 81.49 | 55.2 |
| Mississippi | 35.00 | 57.54 | 60.8 |
| Missouri | 37.50 | 80.52 | 46.6 |
| Montana | 36.50 | 77.84 | 46.9 |
| Nebraska | 34.00 | 72.35 | 47.0 |
| Nevada | 51.92 | 90.57 | 57.3 |
| New Hampshire | 37.00 | 69.11 | 53.5 |
| New Jersey | 40.00 | 90.74 | 44.1 |
| New Mexico | 30.00 | 78.16 | 38.4 |
| New York | 45.00 | 91.25 | 49.3 |
| North Carolina | 35.00 | 61.48 | 56.9 |
| North Dakota | 37.10 | 71.09 | 52.0 |
| Ohio | 40.25 | 92.21 | 43.7 |
| Oklahoma | 35.00 | 77.89 | 44.9 |
| Oregon | 48.46 | 84.47 | 57.6 |
| Pennsylvania | 37.50 | 82.26 | 45.6 |
| Rhode Island | 32.00 | 72.01 | 44.4 |
| South Carolina | 35.00 | 59.69 | 58.6 |
| South Dakota | 30.00 | 68.87 | 43.6 |
| Tennessee | 32.00 | 69.99 | 45.7 |
| Texas | 35.00 | 78.31 | 44.7 |
| Utah | 39.90 | 78.17 | 51.0 |
| Vermont | 34.00 | 69.66 | 48.8 |
| Virginia | 33.00 | 68.63 | 48.1 |
| Washington | 48.46 | 86.98 | 55.7 |

## SCHEDULE D (Cont.)

### RATIO OF MAXIMUM WEEKLY BENEFIT FOR TEMPORARY TOTAL DISABILITY TO AVERAGE WEEKLY WAGES BY STATE*

| State | Maximum Weekly Temporary Total Disability Benefit** | Average Weekly Wage | Ratio Maximum Weekly Temporary Total Disability Benefit to Average Weekly Wage* |
|---|---|---|---|
| West Virginia | $ 33.00 | $ 85.33 | 38.7% |
| Wisconsin | 49.00 | 85.54 | 57.3 |
| Wyoming | 42.46 | 76.71 | 55.4 |
| Alaska | 100.00 | 131.06 | 76.3 |
| Hawaii | 75.00 | 65.38 | 114.7 |
| Puerto Rico | 25.00 | — | — |

*Maximum weekly benefits based on worker, wife and 2 dependent children. Average wages based on wage of workers covered under unemployment insurance laws.

**Maximum weekly temporary total disability benefit—worker, wife and 2 dependent children where additional compensation allowed for dependents.

## SCHEDULE E

### EXHIBIT OF EXPENSE RATIOS—COMPILED FROM INSURANCE EXPENSE EXHIBIT APPROVED BY NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS FOR STATE FUNDS FILING WITH NATIONAL COUNCIL ON COMPENSATION INSURANCE

| Cal. Year | (1) Net Premium Earned Amount | (2) Losses Incurred % | (3) Loss Adjustment Expense % | (4) Commissions and Brokerage % | (5) Other Acquisition % | (6) General Expenses % | (7) Taxes, Licenses and Fees % | (8) Total Expense Incurred % | (9)* Gain From Underwriting Amount | % |
|---|---|---|---|---|---|---|---|---|---|---|
| 1949 | 78,942,531 | 75.8 | 8.2 | 0.3 | 1.7 | 5.8 | 4.3 | 20.3 | 3,058,627 | 3.9 |
| 1950 | 77,565,630 | 76.5 | 7.6 | 0.3 | 1.6 | 6.4 | 4.0 | 19.9 | 2,802,167 | 3.6 |
| 1951 | 88,991,435 | 76.7 | 6.5 | 0.3 | 1.6 | 6.1 | 3.8 | 18.3 | 4,428,747 | 5.0 |
| 1952 | 101,958,917 | 75.1 | 7.4 | 0.3 | 1.5 | 5.8 | 4.3 | 19.3 | 5,734,905 | 5.6 |
| 1953 | 117,645,642 | 66.5 | 7.1 | 0.3 | 1.3 | 5.5 | 4.8 | 19.0 | 17,035,651 | 14.5 |
| 1954 | 118,400,395 | 59.2 | 6.7 | 0.3 | 1.6 | 6.1 | 4.1 | 18.8 | 26,031,599 | 22.0 |
| 1955 | 115,164,078 | 66.8 | 7.2 | 0.3 | 1.5 | 6.4 | 4.1 | 19.5 | 15,810,287 | 13.7 |
| 1956 | 116,583,330 | 66.1 | 7.7 | 0.3 | 1.7 | 6.9 | 3.5 | 20.1 | 16,079,389 | 13.8 |
| 1957 | 114,095,261 | 69.8 | 8.2 | 0.4 | 1.8 | 7.8 | 5.5 | 23.7 | 7,409,364 | 6.5 |

State Funds reporting to National Council on Compensation Insurance: California, Michigan, New York, Pennsylvania.

*Note: The four state funds included in this exhibit pay dividends to their policyholders and it is reasonable to assume that well more than half of the "gains" shown in Column 9 were returned to insureds.

Source: National Council on Compensation Insurance, November 1958.

## SCHEDULE F

### EXHIBIT OF COUNTRYWIDE EXPENSE RATIOS—NON-PARTICIPATING CARRIERS—COMPILED FROM INSURANCE EXPENSE EXHIBIT APPROVED BY NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS FOR COMPANIES FILING WITH NATIONAL COUNCIL ON COMPENSATION INSURANCE

| Cal. Year | (1) Net Premium Earned Amount | (2) Losses Incurred % | (3) Loss Adjustment Expense % | (4) Commissions and Brokerage % | (5) Other Acquisition % | (6) General Expenses % | (7) Taxes, Licenses and Fees % | (8) Total Expense Incurred % | (9) Gain From Underwriting % | (10) Cumulative Net Earned Premium Amount | (11) Cumulative Gain From Underwriting Amount | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1949 | 323,932,185 | 53.1 | 8.2 | 13.9 | 4.0 | 9.0 | 3.8 | 38.9 | 8.0 | 323,932,185 | 25,817,073 | 8.0 |
| 1950 | 312,200,286 | 61.4 | 10.3 | 13.5 | 3.9 | 9.4 | 3.8 | 40.9 | -2.3 | 636,132,471 | 18,517,032 | 2.9 |
| 1951 | 347,919,159 | 66.5 | 9.6 | 12.9 | 3.8 | 8.9 | 3.9 | 39.1 | -5.6 | 984,051,630 | -1,027,053 | -0.1 |
| 1952 | 408,999,574 | 64.1 | 8.8 | 12.4 | 3.6 | 8.3 | 3.8 | 36.9 | -1.0 | 1,393,051,204 | -5,393,150 | -0.4 |
| 1953 | 463,477,825 | 60.6 | 9.1 | 12.2 | 3.4 | 8.1 | 3.7 | 36.5 | 2.9 | 1,856,529,029 | 8,192,197 | 0.4 |
| 1954 | 497,698,251 | 56.4 | 8.8 | 12.3 | 3.3 | 8.5 | 3.5 | 36.4 | 7.2 | 2,354,227,280 | 44,152,624 | 1.9 |
| 1955 | 514,921,193 | 59.9 | 8.7 | 12.5 | 3.3 | 8.5 | 3.5 | 36.5 | 3.6 | 2,869,148,473 | 62,524,138 | 2.2 |
| 1956 | 557,205,203 | 60.2 | 9.0 | 12.6 | 3.4 | 8.4 | 3.4 | 36.8 | 3.0 | 3,426,353,676 | 79,216,475 | 2.3 |
| 1957 | 618,591,802 | 62.1 | 9.0 | 12.4 | 3.2 | 8.2 | 3.8 | 36.6 | 1.3 | 4,044,945,478 | 87,045,283 | 2.2 |

Source: National Council on Compensation Insurance, October 1958.

## SCHEDULE G

### EXHIBIT OF COUNTRYWIDE EXPENSE RATIOS— PARTICIPATING STOCK CARRIERS—COMPILED FROM INSURANCE EXPENSE EXHIBIT APPROVED BY NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS FOR COMPANIES FILING WITH NATIONAL COUNCIL ON COMPENSATION INSURANCE

| Col. Year | (1) Net Premium Earned Amount | (2) Losses Incurred % | (3) Loss Adjustment Expense % | (4) Commissions and Brokerage % | (5) Other Acquisition % | (6) General Expenses % | (7) Taxes, Licenses and Fees % | (8) Total Expense Incurred % | (9) Gain From Underwriting % | (10) Cumulative Net Earned Premium Amount | (11) Cumulative Gain From Underwriting Amount | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1949 | 106,472,719 | 53.4 | 7.5 | 8.1 | 2.9 | 7.6 | 2.3 | 28.4 | 18.2 | 106,472,719 | 19,411,656 | 18.2 |
| 1950 | 106,265,459 | 60.3 | 8.2 | 8.0 | 3.5 | 6.5 | 2.4 | 28.6 | 11.1 | 212,738,178 | 31,190,245 | 14.7 |
| 1951 | 119,006,555 | 69.0 | 8.7 | 7.8 | 3.3 | 6.2 | 2.6 | 28.6 | 2.4 | 331,744,733 | 34,029,111 | 10.3 |
| 1952 | 126,738,843 | 61.6 | 8.2 | 8.2 | 3.4 | 6.4 | 2.7 | 28.9 | 9.5 | 458,483,576 | 46,133,339 | 10.1 |
| 1953 | 136,763,112 | 57.0 | 8.4 | 8.7 | 3.5 | 6.1 | 2.3 | 29.0 | 14.0 | 595,246,688 | 65,228,129 | 11.0 |
| 1954 | 115,718,596 | 52.5 | 8.3 | 8.0 | 4.3 | 6.3 | 2.2 | 29.1 | 18.4 | 710,965,284 | 86,506,382 | 12.2 |
| 1955 | 118,760,665 | 52.4 | 7.9 | 7.8 | 4.1 | 6.2 | 2.3 | 28.3 | 19.3 | 829,725,949 | 109,406,510 | 13.2 |
| 1956 | 128,987,234 | 55.2 | 7.9 | 7.6 | 4.1 | 6.2 | 2.0 | 27.8 | 17.0 | 958,713,183 | 131,283,102 | 13.7 |
| 1957 | 125,159,545 | 58.9 | 7.5 | 7.0 | 4.2 | 6.6 | 2.1 | 27.4 | 13.7 | 1,083,872,728 | 148,458,927 | 13.7 |
| **Exhibit of Countrywide Expense Ratios—Mutual Carriers—Compiled from Insurance Expense Exhibit Approved by National Association of Insurance Commissioners for Companies Filing with National Council on Compensation Insurance** | | | | | | | | | | | | |
| 1949 | 255,234,562 | 57.2 | 6.9 | 2.1 | 5.3 | 6.5 | 3.3 | 24.1 | 18.7 | 255,234,562 | 47,808,963 | 18.7 |
| 1950 | 255,720,572 | 61.9 | 8.0 | 2.2 | 5.2 | 6.5 | 3.1 | 25.0 | 13.1 | 510,955,134 | 81,381,940 | 15.9 |
| 1951 | 296,898,610 | 62.2 | 7.9 | 2.2 | 4.7 | 6.4 | 3.2 | 24.4 | 13.4 | 807,853,744 | 121,163,458 | 15.0 |
| 1952 | 331,629,170 | 62.3 | 7.6 | 2.1 | 4.6 | 6.1 | 3.2 | 23.6 | 14.1 | 1,139,482,914 | 167,731,294 | 14.7 |
| 1953 | 370,511,530 | 59.8 | 8.0 | 2.1 | 4.5 | 6.0 | 3.2 | 23.8 | 16.4 | 1,509,994,444 | 228,536,849 | 15.1 |
| 1954 | 358,440,856 | 55.4 | 7.6 | 2.1 | 4.9 | 6.7 | 2.9 | 24.2 | 20.4 | 1,868,435,300 | 301,638,152 | 16.1 |
| 1955 | 353,174,272 | 57.2 | 7.7 | 2.1 | 5.4 | 7.0 | 2.8 | 25.0 | 17.8 | 2,221,609,572 | 364,711,615 | 16.4 |
| 1956 | 373,731,806 | 58.3 | 8.1 | 2.2 | 5.1 | 7.1 | 2.8 | 25.3 | 16.4 | 2,595,341,378 | 426,042,998 | 16.4 |
| 1957 | 393,594,330 | 57.4 | 8.0 | 2.3 | 5.3 | 7.0 | 3.1 | 25.7 | 16.9 | 2,988,935,708 | 492,408,809 | 16.5 |

Note: In the nine years covered by this schedule, mutual carriers generally paid a 15 per cent dividend on workmen's compensation insurance, leaving them a 1.5 per cent net gain for a modest addition to surplus. Figures with respect to premium returns by participating stock carriers are not available, but it is reasonable to assume that competition from the mutuals led them to return to their insureds all but a small percentage of the underwriting gains shown above.

Source: National Council on Compensation Insurance, November 1958.

## SCHEDULE H

### NEW YORK STATE FUND
### LOSS AND EXPENSE RATIOS, 1953-1957

| | UNDERWRITING RATIOS | | | | ANALYSIS OF EXPENSE | | | |
|---|---|---|---|---|---|---|---|---|
| Year | Net Premiums Earned | Losses Incurred % | Expenses Incurred % | Net Gain | Loss Adjust-ment | Acquisi-tion* | General | Taxes and Fees |
| 1953 | $69,615,194 | 71.9 | 19.8 | 8.3 | 7.3 | .7 | 5.5 | 6.3 |
| 1954 | 69,834,806 | 64.2 | 19.8 | 16.0 | 6.8 | .7 | 6.2 | 6.1 |
| 1955 | 64,754,817 | 69.7 | 21.0 | 9.3 | 7.1 | .8 | 6.9 | 6.2 |
| 1956 | 62,190,210 | 73.4 | 22.1 | 4.5 | 8.2 | .9 | 7.9 | 5.1 |
| 1957 | 57,485,193 | 79.1 | 28.8 | -7.9 | 9.0 | 1.0 | 9.4 | 9.4 |

*Note: The State Fund pays no commission or brokerage; this column includes only "other acquisition" expenses.

Source: New York Insurance Department, *1957 Loss and Expense Ratios.*

## SCHEDULE I

### STATE FUND LOSS AND EXPENSE RATIOS—FIVE YEAR PERIOD (a)

| State | (1) Total of Premiums (000 omitted) | (2) Average Ratio of Losses to Premiums | (3) Average Ratio of Expense to Premiums | (4) Total of Dividends Declared (000 omitted) |
|---|---|---|---|---|
| **Competitive Funds** | | | | |
| Arizona (b) | 36,082 | 34.0 | 10.3 | 1,250 |
| California (c) | 204,753 | 58.4 | 13.5 | 53,063 |
| Colorado (d) | 18,272 | 78.1 | 7.4 | 1,998 |
| Idaho | 4,132 | 83.8 | 15.2 | 50 |
| Michigan | 18,748 | 57.4 | 21.6 | 1,531 |
| New York (e) | 329,762 | 71.9 | 22.3 | 22,691 |
| Penns. (f) | 21,924 | 94.6 | 18.7 | 2,362 |
| Utah | 8,473 | 68.1 | 5.8 | 1,911 |
| **Monopolistic Funds** | | | | |
| Nevada | 18,845 | 91.9 | 9.3 | None |
| North Dakota | 9,084 | 90.1 | 10.3 | None |
| Ohio (g) | 326,809 | 103.6 | 5.0 | None |
| Oregon (h) | 82,811 | 100.4 | 8.4 | None |
| Washington (i) | 128,761 | 71.6 | 7.1 | None |
| West Virginia | 62,263 | 91.3 | 5.9 | None |
| Wyoming | 7,805 | 85.5 | 7.4 | None |

(a) Except as otherwise noted, period covered is 1952-1956. Source: *Argus Casualty & Surety Charts* published by The National Underwriter Company; column (1) represents net premiums written; column (2), losses paid (including loss adjustment expenses) to net premiums written; and column (3), expenses (not including loss adjustment expenses) to net premiums written.

(b) Figures for 1954-1956 only (1952 and 1953 not reported).

(c) Sources: *Best's Insurance Reports (Fire & Casualty)*; California State Compensation Insurance Fund. Column (1) represents direct premiums written; column (2), losses incurred (not including loss adjustment expenses) to premiums earned; and column (3), expenses (including loss adjustment expenses) to premiums earned.

(d) Figures for four years only; 1955 not reported.

(e) Period 1953-1957. Sources: 1957 Loss and Expense Ratios tabulated by New York Insurance Department; *Best's Insurance Reports (Fire & Casualty)*. Column (2) represents losses incurred (not including adjustment expenses) to net premiums written; column (3), expenses (including loss adjustment expenses) to net premiums written.

(f) Sources: Pensylvania Compensation Rating Bureau; *Argus Casualty & Surety Charts.*

(g) Sources: *Best's Insurance Reports (Fire & Casualty)*; *Argus Casualty & Surety Charts.*

(h) Source Oregon State Industrial Accident Commission. Column (1) represents premiums received; column (2), losses incurred (excluding loss adjustment expenses) to premiums earned; and column (3), expenses incurred (including loss adjustment expense) to total income.

(i) Source: Washington Department of Labor and Industries. Column (1) represents premiums received; column (2), claims paid to total premium receipts; and column (3), expenses paid (including loss adjustment expense) to total premium receipts.

# Pre-Trial Discovery of Insurance Coverage and Limits*

JOSEPH N. FOURNIER
*New York, New York*

A DEFENDANT is sued for breach of contract. In advance of trial, is plaintiff entitled to discover the defendant's financial ability to respond in damages? Quite obviously the answer is no. A defendant is sued in tort for negligent operation of his automobile. In advance of trial, is plaintiff entitled to discover the defendant's financial ability to pay the anticipated judgment? Here too the answer is an obvious no. In personal injury litigation defendant may carry a public liability policy. In advance of trial should plaintiff be entitled to discover this fact—including the policy limits?

Recently, in California, a woman brought an action for malpractice against her doctor, seeking damages for personal injuries.[1] In a pre-trial examination, the plaintiff, through interrogatories, sought to elicit the following information from the defendant:[2]

(a) Do you have malpractice insurance?

(b) If so, state the name and address of the insurer and policy limits.

The defendant objected to the interrogatories propounded but was overruled. His petition for a writ of prohibition seeking to nullify the order of the lower court which compelled him to answer the interrogatories was denied by the Supreme Court of California.[3]

Is this result desirable or proper?

Under prevailing state and federal court procedures may the plaintiff compel the defendant to disclose the existence of insurance coverage and the extent of his policy limits in personal injury litigation by employing the three major methods of securing pre-trial discovery, viz., (1) deposition, (2) written interrogatories, and (3) discovery and production of documents, in this instance, the insurance policy?[4] Discovery procedure also includes the order to perpetuate testimony in a contemplated action.

The purpose of this article is to examine the pertinent federal and state rules and statutes and survey the cases in point to ascertain whether pre-trial discovery of insurance coverage in personal injury litigation is proper under existing discovery procedure. Our study will not encompass the medical payment endorsement on a public liability policy which is not an indemnity for negligence but rather a contract for payment by the insurer through the insured though the insured may be without fault.

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*During World War II he served as an Infantry officer in North Africa and Italy and as the Administrative officer of the Piedmont Region of Northern Italy in the Allied Military Government. He is also a graduate of the Army's famed Command and General Staff College, Ft. Leavenworth, Kansas and holds a commission as a Lieut. Col. Infantry, USAR.*

*Mr. Fournier practiced law for several years in Syracuse, New York, and was a full time faculty member of the Syracuse University College of Law from 1955 to 1958. Since September 1958 he has been teaching at Fordham University's School of Law, and is an Associate Professor of Law.*

## I. RULES AND STATUTES ON DISCOVERY

### A. *History of Discovery*

Historically, discovery branched off from the auxilliary jurisdiction of the court of

*Reprinted, by permission, from the Fordham Law Review, Summer, 1959. For recent developments, subsequent to the original publication, see the post article footnote.

[1] Laddon v. Superior Court, 334 P. 2d 638 (Cal. 1959).

[2] Id. at 638.

[3] Id. at 640.

[4] See, e.g., Young, Discovery by plaintiff of Defendant's Liability Insurance Coverage, 403 Ins. L. J. 503 (1956); Lavorci, Disclosure of Insurance Policy Limits, 415 Ins. L.J. 505 (1957); Williams, Discovery of Policy Limits, 26 Ins. Counsel J. 225 (1959).

chancery. It was devised to overcome defects in the rigid common law procedure. Initially, discovery was used in equity in aid of the principal common law action, then for the taking of testimony of witnesses in advance of trial, and finally to perpetuate testimony in aid of a contemplated action.[5] These basic principles are today codified in most jurisdictions.[6] New York was the first state to embark on procedural reform by adopting the Code of Civil Procedure of 1848.[7] The Federal Rules of Civil Procedure[8] represent the most recent important procedural innovation. A majority of the states have patterned their practice after one or the other. To some the federal rules are a procedural utopia of liberalism, while New York practice, including discovery procedure, has been depicted as outmoded[9]—a view, however, not shared by all scholars.[10]

### B. *Applicable Federal Rules*

Rule 26(b) of the Federal Rules of Civil Procedure provides in part that the deponent may be examined regarding any unprivileged matter which is relevant to the pending action, whether the matter relates to the claim or the defense of the examining party or to the claim or defense of any other party. It is not a basis for objection that the testimony will not be admissable at the trial if the testimony sought appears reasonably calculated to lead to the discovery of admissible evidence.

Rule 26 permits the taking of testimony by oral deposition or written interrogatories while rule 33 provides that any party may serve upon any adverse party written interrogatories to be answered by the one upon whom such interrogatories have been served. Such interrogatories, however, are limited to matters which can be inquired into under rule 26(b).

Rule 34 states: "Upon motion of any party showing good cause therefor . . . the court in which an action is pending may . . . order any party to produce and permit the inspection and copying or photographing, by or on behalf of the moving party, any designated documents, papers, books, accounts . . . which constitute or contain evidence relating to any of the matters within the scope of the examination permitted by Rule 26(b). . . ."

When the desired testimony is to be taken by oral deposition, rights under rules 26, 26(b), and 34 are limited by rule 30 which authorizes the court to order that the deposition not be taken, or the taking thereof be restricted, upon a showing of good cause, or bad faith on the part of the party taking the deposition, or upon a showing that the taking of the deposition will unreasonably annoy, embarrass, or oppress the deponent or a party. Rule 31 has the same effect when the desired testimony is to be taken by written interrogatories.

### C. *New York Statutes*

The relevant New York statutes are found in the Civil Practice Act Section 288 (testimony by deposition), Section 296 (production of books and papers), Section 302 (manner of taking testimony including written interrogatories), and Section 324 (power of court of record to order production, discovery and inspection of documents). The basic difference between the New York statutes and the federal discovery rules is that in the former the testimony or disclosure sought must be material and necessary to the prosecution or defense of the action and, hence, admissible as evidence. Thus, in a New York suit where recovery of exemplary damages is possible, plaintiff may not delve into defendant's financial status in pre-trial examination.[11]

[5]State v. Second Judicial Dist., 69 Nev. 204, 245 P.2d 999 (1952); 1 Pomeroy, Equity Jurisprudence §§ 190-92 (5th ed. Symons 1941).

[6]See, e.g., Fed. R. Civ. P. 26-37; N.Y. Civ. Prac. Act §§ 288-328. See also Annot., 66 A.L.R. 1264 (1930); Annot., 1910 L.R.A. 462. Prior to the merger of law and equity in New York, effected by the adoption of the Code of Civil Procedure of 1848, infra note 7, the procedural device for obtaining disclosure was the Equitable Bill of Discovery. N.Y. Civ. Prac. Act § 345 now provides that an ancillary action to obtain discovery under oath in aid of prosecuting or defending an action cannot be maintained. Therefore, the right to a bill of discovery no longer survives in view of the complete remedy afforded by existing statutes. Fur & Wool Trading Co. v. George I. Fox, Inc., 245 N.Y. 215, 156 N.E. 670 (1927).

[7]N.Y. Sess. Laws 1848, ch. 379.

[8]28 U.S.C. § 2072 (1952).

[9]Clark & Wright, The Judicial Council and The Rule-Making Power: A Dissent and a Protest, 1 Syracuse L. Rev. 346, 352 (1950).

[10]See, e.g., Rothschild, Federal Wonderland, 18 Brooklyn L. Rev. 16 (1952).

[11]Wilson v. Onondaga Radio Broadcasting Corp., 175 Misc. 389, 23 N.Y.S.2d 654 (Sup. Ct. 1940). Cases are legion which have held that in actions for damages for injury to person or property, evidence that a defendant was insured against such damages is incompetent. See, e.g., Simpson v. Foundation Co., 201 N.Y. 479, 95 N.E. 10 (1911). Even on voir dire examination the plaintiff may not carry to the jury the implication that liability in-

Under the federal rules, it suffices if the information sought by an examination is relevant to the subject matter of the pending action, and it is not necessary to establish the admissibility of the testimony.[12]

## II. Injured Party's Action Against Wrongdoer's Insurer

There are several types of state statutes which regulate casualty insurance carriers. Louisiana[13] and Wisconsin[14] allow the victim of a personal injury to bring a joint action against the tortfeasor and the insurer or directly against the insurer alone. Louisiana courts have characterized the "direct action" statute as creating a separate and distinct cause of action against the insurer which the injured party may elect in lieu of his action against the tortfeasor.[15] The constitutionality of this statute has been upheld by the Supreme Court of the United States in a case where there was diversity of citizenship between plaintiff and the defendent-insurer but no such diversity between plaintiff and the insured tortfeasor.[16] It was also affirmed where the insurance contract was negotiated and delivered outside the state in which the action was brought, even though the policy expressly prohibited actions against the insurer until after a final determination of defendant's obligation to pay personal injury damages by judgment or agreement.[17] The Second Circuit Court of Appeals has held that where neither party is a resident of the state in which the action is brought, the substantive law is determined by the place where the cause of action accrued, while the law of the forum controls procedure.[18]

The second type of statute is represented by that of Minnesota[19] which permits an action against the insurer after an execution against the judgment debtor is returned unsatisfied, and also that of New York[20] which permits an action against the insurer where a judgment against the insured remains unsatisfied for 30 days or more. A third type statute, not directly touching an insurance carrier, is the New Jersey Unsatisfied Claim and Judgment Fund Law[21] Here the victim of a personal injury holding an unsatisfied claim or judgment in the amount of $200 or more may proceed against the Director of the Division of Motor Vehicles to recover from the fund. It is interesting to note that

[12]Stevenson v. Melady, 1 F.R.D. 329 (S.D.N.Y. 1940). Although it is not necessary to establish the admissibility of the testimony sought, nevertheless, it should lead to facts or information which are themselves admissible in evidence.

[13]La. Rev. Stat. § 655 (1950).

[14]Wis. Stat. § 85.93 (1929), construed in Kujawa v. American Indem. Co., 245 Wis. 361, 14 N.W.2d 31 (1944).

[15]West v. Monroe Bakery, 217 La. 189, 46 So. 2d 122 (1950); Jackson v. State Farm Mut. Auto. Ins. Co., 211 La. 19, 29 So. 2d 177 (1946).

[16]Lumberman's Mut. Cas. Co. v. Elbert, 348 U.S. 48 (1954). Plaintiff, a Louisiana resident, brought an action in a Louisiana court against the insurer, an Illinois corporation. The contract was entered into outside the state.

[17]Watson v. Employers Liab. Corp., 348 U.S. 66 (1954).

[18]Collins v. American Auto Ins. Co., 230 F.2d 416 (2d Cir. 1956). Plaintiff was a citizen of Virginia and defendant a Missouri corporation. The action was brought in a federal district court in New York to enforce rights accruing under Louisiana law. Cf. Morton v. Maryland Cas. Co., 4 N.Y.2d 488, 151 N.E.2d 881, 176 N.Y.S.2d 329 (1958). Plaintiff, a resident of New York, was injured in Louisiana and suit was brought in New York. The Louisiana statute providing for a direct action against the insurer includes a provision that "the injured person or his or her heirs, at their option, shall have a right of direct action against the insurer within the terms and limits of the policy in the parish where the accident or injury occurred or in the parish where the insured has his domicile, and said action may be brought against the insurer alone or against both the insured and insurer, jointly or in solido." La. Rev. Stat. § 655 (1950). Hence, the statute creates a substantive right and the action is local and not transitory.

As a condition precedent to doing business in Louisiana, the defendant insurer was required to consent to suits by persons injured in Louisiana accidents. In denying plaintiff the right to maintain the action in New York, the court of appeals said that "defendant was never asked to agree nor did it ever agree that a direct suit could be brought against it elsewhere than in Louisiana." 4 N.Y.2d 494, 151 N.E.2d at 883, 176 N.Y.S.2d at 331.

[19]Minn. Stat. Ann. § 60.51 (1937).

[20]N.Y. Ins. Law § 167 (1) (b).

[21]N.J. Stat. Ann. § 39:6-79 (1958).

surance is carried by the defendant. Gebo v. Findlay, 257 App. Div. 66, 11 N.Y.S.2d 950 (4th Dep't 1939). Accord, Tom Reed Gold Mines Co., v. Morrison, 26 Ariz. 281, 224 Pac. 822 (1924); Lord v. Poore, 9 Terry 595, 108 A.2d 366 (1954). In a matriminial action, the property interest of the husband will not be inquired into on a pre-trial examination for the purpose of ascertaining the amount of alimony which the husband should pay. Plaintiff wife must first establish that she is entitled to the matrimonial relief she seeks. 4 Carmody, New York Practice § 1236, at 2806 (2d ed. 1932). Wenglinsky v. Wenglinsky, 282 App. Div. 1015, 126 N.Y.S.2d 249 (1st Dep't 1953); Safrin v. Safrin, 205 App. Div. 628, 200 N.Y.S. 51 (2d Dep't 1923); Van Valkenburg v. Van Valkenburg, 149 App. Div. 482, 133 N.Y.S. 942 (1st Dep't 1912). Cf. Kirshner v. Kirshner, 7 App. Div. 2d 202, 182 N.Y.S.2d 286 (2d Dep't 1959); Jasne, v. Jasne, 10 Misc. 2d 59, 174 N.Y.S.2d 822 (Sup. Ct. 1952). The rationale of the latter two cases is that the plaintiff wife should try her right to matrimonial relief, alimony and the amount thereof at one and the same time.

where a non-resident attempts to recover from the fund, the New Jersey court will look to the law of the plaintiff's residence to see if New Jersey domiciliaries are there afforded similar relief as that provided by New Jersey. If not, and reciprocity is not granted, the non-resident plaintiff cannot recover.[22]

## III. Purpose of Discovery

### A. *General*

What is the purpose of discovery procedure?

In *Hickman v. Taylor*,[23] the Supreme Court of the United States stated that "discovery like all matters of procedure, has ultimate and necessary boundaries."[24] The several instruments of discovery "now serve (1) as a device, along with the pre-trial hearing under Rule 16, *to narrow and clarify the basic issues between the parties, and* (2) *as a device for ascertaining the facts, or information as to the existence or whereabouts of facts, relative to those issues.*"[25]

Barron and Holtzoff[26] state:

"Discovery has three distinct purposes and uses . . .

(1) To narrow the issues, in order that at the trial it may be necessary to produce evidence only as to a residue of matters which are found to be actually disputed and controverted.

(2) To obtain evidence for use at the trial.

(3) To secure information as to the existence of evidence that may be used at the trial and to ascertain how and from whom it may be procured, as for instance, the existence, custody and location of pertinent documents or the names and addresses of persons having knowledge of the relevant facts."

In reference to the pre-trial examination of another party, Carmody states that "the matter upon which the examination is based . . . must be material. Therefore, it should ordinarily be confined to the issues raised by the pleadings."[27]

Materiality means relevancy and relevancy relates to evidentiary matter which tends to prove or disprove a proposition. Whether a proposition is provable in a particular case is determined by the pleadings, by the procedural rules applicable thereto, and by the substantive law governing the issues in litigation.[28]

### B. *Decisions*

Decisions in both state and federal courts on the question of whether insurance coverage and policy limits are subject to discovery under existing rules reveal large areas of disagreement.

In the New Jersey case of *Goheen v. Goheen*,[29] plaintiff attempted, through interrogatories, to elicit information as to (1) whether defendant was insured, (2) the name of the company, (3) whether the policy was in force or cancelled, (4) whether the premium was paid up, and (5) the amount of insurance. In granting defendant's motion to strike out the interrogatories, the court held that the desired interrogatories were not probative of the issue and thus irrelevant and incompetent evidence.[30]

On the other hand, the Michigan Supreme Court, in *Layton v. Cregan & Mallory Co.*,[31] in permitting discovery of insurance by requiring the defendant to produce the policy for examination, stated the limited purpose of such discovery:

> It is first contended by the defendant that the plaintiff is not entitled to a discovery because it calls for matters entirely foreign and irrelevant to the issue. We do not think so. *The ownershop of the car was put in issue by the pleadings. If the insurance policy shows ownership, it is admissible in evidence for that purpose.*[32]

In 1937, the Supreme Court of California declared in *Demaree v. Superior Court*,[33] dealing with an order for the perpetuation of testimony in a contemplated action: "We think it must be conceded that the provi-

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[22]Betz v. Director of Div. of Motor Vehicles, 47 N.J. Super, 449, 136 A.2d 53 (L. 1957).

[23]329 U.S. 495 (1947).

[24]Id. at 507.

[25]Id. at 501. (Emphasis added.)

[26]2 Barron & Holtzoff, Federal Practice and Procedure § 641, at 263 (1950).

[27]4 Carmody, New York Practice § 1236, at 2804 (2d ed. 1932).

[28]James, Relevancy, Probability and the Law, 29 Calif. L. Rev. 689 (1941).

[29]9 N.J. Misc. 507, 154 Atl. 393 (Cir. Ct. 1931).

[30]Id. at 508, 154 Atl. at 393.

[31]263 Mich. 30, 248 N.W. 539 (1933).

[32]Id. at 31-32, 248 N.W. at 539. (Emphasis added.) It is to be noted that in producing the policy defendant may also be disclosing the policy limits. Even so, such disclosure is only ancillary to the real dispute which is the ownership of the automobile placed in issue by the pleadings. It is not in any way connected with defendant's financial responsibility.

[33]10 Cal. 2d 99, 73 P.2d 605 (1937).

sions of the policy of insurance are germane to petitioner's cause and material to their anticipated action, when and if brought. We are of the view, therefore, that the applicants laid a sufficient basis for the issuance of the order providing for the perpetuation of testimony and the production of the insurance policy."[34]

The Appellate Division of New York in *McGrath v. Vaccaro*[35] upheld the plaintiff's right to discover and inspect defendant's liability insurance policy where the defendant had denied control of the instrument which caused the injury. Hence, liability insurance was material and relevant to the issue of control raised by the pleadings and, therefore, admissible in evidence.[36]

In *Orgel v. McCurdy*,[37] a case involving pre-trial examination under rule 26(b), the District Court for the Southern District of New York stated:

> Defendant objects to examination on these matters (liability insurance) on the ground that the 'injection of this issue in the trial of this action will seriously prejudice the defendant . . . in its defense and would have no probative value on the *contested issue of operation and control of the vehicle involved in the accident.*' . . . (Plaintiff) 'on the issue of liability insurance, is attempting to spell out operation and control from the fact of insurance liability coverage, when, as a matter of fact, whether the defendant . . . had liability insurance coverage on the vehicle in question at the time of the accident would depend on whether the said motor vehicle was under its operation and control."[38]

Examination here was granted because the testimony sought by the plaintiff could be generally relevant to the issues in the case.

A wider latitude for examination in this respect was granted by a district court of Tennessee in *Brackett v. Woodall Food Prods., Inc.*,[39] a case concerning discovery under rule 34. The court believed that examination of the liability insurance policy of the alleged tortfeasor was proper because it was relevant and material to the subject matter of the litigation, and thus within the purview of rules 34 and 26 (b).[40]

However, this liberal view was repudiated in *McClure v. Boeger*,[41] which also involved discovery under rule 34. The federal district court stated that "whatever advantages the plaintiff might gain are not advantages which have anything to do with his presentation of his case at trial and do not lead to disclosure of the kind of information which is the objective of discovery procedure. . . . [T]o grant this motion would be to unreasonably extend that procedure beyond its normal scope and would not be justified."[42]

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[34]Id. at 103, 73 P.2d at 607.

[35]270 App. Div. 948, 62 N.Y.S.2d 244 (2d Dep't 1946). Accord, La Fata v. News Syndicate Co. Inc., 269 App. Div. 818, 56 N.Y.S.2d 199 (1st Dep't 1945).

[36]The case of Martyn v. Braun, 270 App. Div. 768, 59 N.Y.S.2d 588 (2d Dep't 1946), was misconstrued in 415 Ins. L.J. 505, 507 (1957). Plaintiff fell on a stoop, control of which defendant had denied. The court held that plaintiff's motion for examination before trial of the defendant on the matter of liability insurance should have been allowed. However, the question if insurance was material and relevant since defendant had denied control of the premises. That being so, it was admissible in evidence as relevant. In Milk Tank Serv., Inc. v. Wood, 200 Misc. 333, 107 N.Y.S.2d 166 (Supp. Ct. 1951), an examination before trial of the plaintiff was disallowed in an action to recover property damage to a truck and cargo where the defendant sought to ascertain whether the truck and cargo were insured, and if so, the name of the insurance company and the amount of the insurance. Accord, Rashall v. Morra, 250 App. Div. 474, 294 N.Y.S. 630 (2d Dep't 1937).

[37]8 F.R.D. 585 (S.D.N.Y. 1948).

[38]Ibid. (Emphasis added.) The language used clouds the fact that the real issues in dispute were control and operation of the vehicle in question, making insurance coverage relevant and material, thus admissible evidence.

[39]12 F.R.D. 4 (E.D. Tenn. 1951).

[40]Id. at 5. The court asserted that the policy "may afford the plaintiffs rights of which they would otherwise not be able to avail themselves." Id. at 6. This is the first instance in which the novel theory is advanced that knowledge of the details of the defendant's insurance coverage is material to the plaintiff in the preparation of his case for trial. This means plaintiff may discover insurance to evaluate his case. When Brackett was decided, Tennessee had in force a financial responsibility law. Tenn. Code Ann. §§ 2715.49-.68 (1951). It required motorists, under certain circumstances, to show financial responsibility by posting bonds or carrying liability insurance. The court inferred from this a legislative intent to make insurance policies relevant in negligence cases. Comparable legislation was then in force in over 40 of the 48 states.

This same court declared in McNelley v. Perry, 18 F.R.D. 360 (E.D. Tenn. 1955), with regard to discovery of insurance through interrogatories under federal rule 26, that "as a general rule, the purpose of seeking information from an adversary, or a witness, is two-fold: (1) to use it in the trial, or (2) to use it as a lead to information for use in the trial. It is not shown in this case that the information sought about insurance would be relevant to either purpose." Id. at 361.

[41]105 F. Supp. 612 (E.D. Pa. 1952).

[42]Id. at 613.

In *Superior Ins. Co. v. Superior Court*,[43] which dealt with an order for the perpetuation of testimony in a contemplated action, the California Supreme Court ruled that a witness could be compelled to testify with reference to an insurance policy. The court not only held that the policy itself must be produced, but also that the witness should not be permitted to restrict his testimony merely to the fact that insurance exists. Furthermore, the court observed that "an automobile liability policy evidences 'a contractual relation created by statute which inured to the benefit of any and every person who might be negligently injured by the assured as completely as if such injured person had been specifically named in the policy', i.e., a contractual relation is 'created between the insurer and the third parties'."[44] However, the majority of the court overlooked the fact that a suit against the insurer is not an action to recover a loss under the policy, but constitutes an action for reimbursement for damages sustained.[45] No liability under the policy accrues as an enforceable claim against the insurer until judgment against the insured becomes final,[46] and discovery of insurance may be had in a proceeding supplementary to judgment.[47]

The Kentucky Court of Appeals, in *Maddox v. Grauman*,[48] with respect to the discovery of insurance in a pre-trial examination under a statute similar to federal rule 26 (b), declared that: "An insurance contract is no longer a secret, private, confidential arrangement between the insurance carrier and the individual but it is an agreement that embraces those whose person or property may be injured by the negligent act of the insured. We conclude the answers to the propounded questions are relevant to the subject matter of the litigation . . . ."[49]

The Minnesota Supreme Court, in *Jeppesen v. Swanson*,[50] handed down an exhaustive, well-reasoned opinion on discovery procedure under a rule nearly identical with federal rule 34. Plaintiff's attorneys frankly stated in the moving papers that the motion to inspect defendant's liability policy was to place a value on the case for the purpose of settlement.[51] The Court denied the plaintiff's petition and, relying on the *Hickman*[52] and *McClure*[53] cases, stated:

> The rationale of the great bulk of federal cases dealing with the discovery rules is that the information sought by the discovery must either be admissible on a trial of the issues involved in the case or it must be such facts or information as will lead to the discovery of evidentiary information in some way related to the proof or defense of issues involved in the trial of the case.[54]

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[43]37 Cal. 2d 749, 235 P.2d 833 (1951). The Supreme Court of Nevada in State v. Second Judicial Dist. Court, 69 Nev. 196, 245 P.2d 999 (1952), distinguished the Superior case on the ground that in view of Cal. Ins. Code § 11580 which provides that insurance contracts must contain a provision to the effect that in the event of an unsatisfied judgment against the insured, the plaintiff could sue the insurer, the plaintiff therefore had a discoverable interest in the defendant's insurance policy, whereas, in Nevada, no similar statute was in force. Nevada however, did have a financial responsibility statute similar to that in force in Tennessee. See Brackett v. Woodall Food Prods., Inc., 12 F.R.D. 4 (E.D. Tenn. 1951).

Under the federal rules, to obtain discovery by an order to perpetuate testimony in a contemplated action, plaintiff is required to show a possibility that the testimony sought might otherwise be lost. Petition of Ferkouf, 3 F.R.D. 89 (S.D.N.Y. 1943). It can hardly be contended that this possibility exists when a large insurance company is involved, assuming, arguendo, that discovery is proper in the first instance. N.Y. Civ. Prac. Act § 295 provides: "Testimony which is material to an expected party in the prosecution or defense of an action about to be brought may be taken by deposition if the taking or the preservation thereof is necessary for the protection of his rights. Such testimony may be taken only in pursuance of an order of the court in which the action may be brought or a judge thereof."

[44]37 Cal. 2d at 754. 235 P.2d at 835.

[45]Olds v. General Acc. Fire & Life Assur. Corp., 67 Cal. App. 2d 812, 155 P.2d 676 (1945).

[46]Levy v. Superior Court, 74 Cal. App. 171, 239 Pac. 1100 (1925).

[47]Cal. Ins. Code § 11580 permits action against the insurer after judgement has been obtained against the insured. Cal. Ins. Code § 11581 provides: "Upon any proceeding supplementary to execution such judgement debtor may be required to exhibit any policy carried by him insuring against the liability for the loss or damage for which judgement was obtained." Minn. Stat. Ann. § 60.51 (1937) provides for examination of judgement debtor after execution is returned unsatisfied. N.Y. Civ. Prac. Act § 775 provides for the examination of a judgement debtor in a proceeding supplementary to judgement after the docketing of the judgement, and the examination need not await an execution being returned unsatisfied. N.Y. Civ. Prac. Act § 779 provides for examination of third parties, individual, partnership or corporation, who may be holding property of judgement debtor or be indebted to him.

[48]265 S.W.2d 939 (Ky. 1954).

[49]Id. at 942.

[50]243 Minn. 547, 68 N.W.2d 649 (1955).

[51]Id. at 548, 68 N.W.2d at 653.

[52]Hickman v. Taylor, 329 U.S. 495 (1947).

[53]McClure v. Boeger, 105 F. Supp. 612 (E.D. Pa. 1952).

[54]243 Minn, at 554, 68 N.W.2d at 653.

Another state court, also construing a discovery statute similar to federal rule 34, denied a plaintiff pre-trial discovery of insurance coverage, reasoning that it was neither material nor relevant, and was hence inadmissible as evidence.[55] In so deciding, the South Dakota Supreme Court declared that the "plaintiff's suggestion that the policy may afford her rights of which she would not be able to avail herself unless she is permitted to inspect it, does not concern the pending lawsuit. *Rather it concerns a subsequent suit against the insurer—if she prevails in this one.*"[56]

A more liberal stand was taken by the Supreme Court of Illinois in *People ex rel. Terry v. Fisher.*[57] The court denied defendant's petition for a writ of mandamus directed to the judge who had ordered the defendant to answer plaintiff's interrogatories containing the following questions: (1) On the date of this lawsuit did you carry liability insurance? (2) If so, with what company? (3) If you did carry liability insurance, what is the policy limit for each person? The Illinois court, relying on the *Brackett,*[58] *Superior*[59] *and Maddox*[60] cases in arriving at its decision, stated:

> It is our opinion that discovery interrogatories respecting the existance and amount of defendant's insurance may be deemed to be 'related to the merits of the matter in litigation' . . . since they apprise injured plaintiffs of rights arising out of the accident, otherwise unknown, and which the public policy of this State protects, give counsel a realistic appraisal of his adversary and of the case he must prepare for, and afford a sounder basis for the settlement of disputes. We believe that such a construction is in accordance with the intention of the framers of the amended Rules to give a broader scope to the practice of discovery and thereby enable attorneys to better prepare and evaluate their cases.[61]

The liberal position exemplified by the *Superior* case has been explicitly rejected by the Supreme Courts of Oklahoma[62] and Florida.[63] In *Brooks v. Owens,*[64] wherein plaintiff had endeavored to discover defendant's insurance policy limits through interrogatories, the Florida Supreme Court specifically declined to follow the *Superior* and *Maddox* decisions and declared:

> We adopt the view . . . that the limits of liability insurance on a policy covering an automobile of a defendant are not proper matters subject to discovery . . . . *It is our view that the rule is applicable only to those matters admissible in evidence or calculated reasonably to lead to the discovery of admissible evidence.*[65]

Two recent decisions[66] by federal district courts in Illinois demonstrate a consistent denial of the use of interrogatories to discover the existence and limits of any insurance. In *Gallimore v. Dye,*[67] the federal court pointed out that the presence or absence of insurance by the defendant has no bearing on the issue of liability in negligence actions, for the defendant's negligence "is the gravamen in such actions."[68] The Court went on to assert that "the plaintiff's cause must rise or fall on its own merits and on the ability of the plaintiff to prove liability against the defendant."[69] Adhering to the *Gallimore* case, the

[55]Bean v. West, 76 S.D. 462, 80 N.W.2d 565 (1957).

[56]Id. at 465, 80 N.W.2d at 567. (Emphasis added).

[57]12 Ill. 2d 231, 145 N.E.2d 588 (1957). The court also observed that in personal injury litigation the insurer is virtually substituted as a party since it controls the investigation of the case and the conduct of the defense. Therefore, plaintiff has a discoverable interest in defendant's insurance coverage as a matter of public policy. Should it not then logically follow that plaintiff has the same discoverable interest in an uninsured defendant's assets, who controls the investigation of the case, and the conduct of the defense?

[58]Brackett v. Woodall Food Prods., Inc., 12 F.R.D. 4 (E.D. Penn. 1951).

[59]Superior Ins. Co. v. Superior Court, 37 Cal. 2d 749, 235 P.2d 833 (1951). See note 43 supra.

[60]Maddox v. Grauman, 265 S.W.2d 939 (Ky. 1954).

[61]12 Ill. 2d at 239, 145 N.E.2d at 593.

[62]Peters v. Webb, 316 P.2d 170 (Okla. 1957). Involved here was the perpetuation of testimony by deposition in a contemplated action for malpractice. The Oklahoma Supreme Court denied plaintiff the right to discovery of insurance coverage.

[63]Brooks v. Owens, 97 So. 2d 693 (Fla. 1957).

[64]Ibid.

[65]Id. at 699. (Emphasis added.)

[66]Roembke v. Wisdom, 22 F.R.D. 198 (S.D. Ill. 1958); Gallimore v. Dye, 21 F.R.D. 283 (E.D. Ill. 1958). Both cases concerned the discovery of insurance and policy limits through interrogatories under rule 33 of the Federal Rules of Civic Procedure.

[67]21 F.R.D. 283 (E.D. Ill. 1958).

[68]Id. at 286.

[69]Continuing this line of reasoning the court said it failed "to see how the presence or absence of liability insurance can have any probative value in this case. It does not, and could not have any bearing on the liability or non-liability of the defendant; nor does this court conceive how receiving answers to the interrogatories objected to here could lead to any matters having any probative force in deciding the issues in this case, nor aid the

Federal District Court for the Southern District of Illinois in *Roembke v. Wisdom*[70] thus summarized the significance of the discovery procedure:

> The purpose of discovery is for preparation for trial. A party by use of the discovery rules, may obtain direct evidence for use in trial, or may obtain pertinent information that will lead to evidence for use in trial. The scope of discovery is broad, and so long as information sought by interrogatories or deposition can reasonably be said to lead to the discovery of admissible evidence it must be given . . . . The existence or non-existence of liability insurance is not an evidentiary matter that may be used at the trial, nor is it relevant to the subject matter involved in the pending action.[71]

Arizona and Connecticut, whose procedural rules are patterned after the federal model, have similarly construed their rules as denying the plaintiff the right to elicit insurance information through interrogatories. As the Arizona Supreme Court stated in *Di Pietruntonio v. Superior Court*,[72] "the decisions holding against discovery . . . are better reasoned than those holding to the contrary."[73] The Superior Court of Delaware[74] pointed out that the prejudicial nature of any mention of liability insurance in an automobile collision case, together "with a complete lack of any showing of relevancy to the issues as framed by the pleadings or otherwise indicated by the plaintiff" necessitated the denial of information relating to insurance coverage and policy limits by means of interrogatories.[75]

Disclosure of insurance coverage through depositions was rejected by the Connecticut Superior Court in *Verrastro v. Grecco*.[76] The court maintained that the "good cause" required by the prevailing rules of practice included a showing that the "disclosure sought would be of assistance in the prosecution or defense of such action."[77] Citing the *Verrastro* decision as controlling, this same court denied a motion for production of defendant's insurance policy in a malpractice suit where the plaintiff attempted to show "good cause" by alleging that she needed to discover whether a statutory violation was covered by the policy so that it might be determined whether or not to include the violation in her complaint as a cause of action.[78]

California has persisted in a liberal construction of its procedural rules so that plaintiffs have been able to elicit insurance coverage information, including policy limits, through the use of interrogatories. This is aptly manifested in the recent decision of *Laddon v. Superior Court*.[79] In following the position previously enunciated in the *Superior*[80] case, the *Laddon* court admitted that "the conclusion is inescapable that under this [*Superior*] decision the insurance policy is relevant to the subject matter involved in the personal injury action, although not strictly within the issues raised by the pleadings."[81] However, recognizing that its view point was perhaps somewhat tenuous, the court conceded that "while the decisions favoring discovery are persuasive in their reasoning, we might be inclined to follow the majority view if the question were wholly new in California."[82]

### C. *Summary of Decisions*

Thus, according to the authority of the preceding cases taken from the federal district courts of Illinois, New York, Pennsylvania and Tennessee, and the state courts

[70]22 F.R.D. 198 (S.D. Ill. 1958).

[71]Id. at 199.

[72]84 Ariz. 291, 327 P.2d 746 (1958). The court stated that: "Our public policy . . . is diametrically opposed to respondent's position and Rule 26(b) . . . construed most favorably in favor of the right of discovery in the instant case does not justify it." 84 Ariz. at 298, 327 P.2d at 751.

[73]Ibid.

[74]Ruark v. Smith, 147 A.2d 514 (Del. Super. Ct. 1959). The Delaware court in construing Del. Super. Ct. (Civ.) R.33, which is similar to the corresponding federal rule of procedure, denied plaintiff insurance coverage information sought by means of interrogatories. 147 A.2d at 515.

[75]147 A.2d at 515.

plaintiff in establishing his cause by a preponderance or greater weight of the evidence which, under the law, he is required to do, before he is entitled to collect anything from the defendant." 21 F.R.D. at 286.

[76]21 Conn. Supp. 165, 149 A.2d 703 (Super. Ct. 1958).

[77]Id. at 166, 149 A.2d at 704.

[78]McKee v. Walker, 21 Conn. Supp, 168, 149 A.2d 704 (Super. Ct. 1958).

[79]334 P.2d 638 (Cal. 1959). See notes 1-3 supra and accompanying text. The pertinent rules were Cal. Civ. Proc. §§ 2016(b), 2030(b) (1957), which are based largely upon the federal rules of procedure.

[80]37 Cal. 2d 749, 235 P.2d 833 (1951).

[81]334 P.2d at 640.

[82]Id. at 639.

of Arizona, Connecticutt, Delaware, Florida, Michigan, Minnesota, Nevada, New Jersey, New York, Oklahoma, and South Dakota, it is clear that a plaintiff cannot compel disclosure of defendant's insurance coverage.[83] It may be argued that the evidence elicited by such disclosure would be inadmissible, because neither material nor relevant, *unless* such disclosure is required to show ownership, agency or control of the vehicle or instrumentality involved. However, as has been seen, the rule is otherwise in the Federal District Court for the Eastern District of Tennessee and the state courts of California, Illinois and Kentucky.[84] These cases hold that disclosure of defendant's insurance coverage may be compelled since the evidence adduced thereby would be relevant to the issues in litigation and within the purview of discovery procedure.

The conflicting arguments may be summarized as follows: The proponents of insurance discovery contend that it is proper inasmuch as (1) discovery rules were adopted as procedural tools to effectuate the prompt and just disposition of litigation by informing the parties in advance of trial as to the real value of their claims and defenses, and should be liberally construed; (2) an automobile liability policy evidences a contractural relationship which inures to the benefit of any person who might be negligently injured by the insured;[85] (3) discovery of the existence and extent of a defendant's liability policy is related to the merits of the subject matter of the litigation and is thus material and relevant; and (4) such discovery, furthermore, would give plaintiff's counsel a realistic appraisal of his case and allow a sounder basis for settlement. While the opponents of discovery concede that the rules should be liberally construed, they contend that discovery here is improper since (1) the purpose of existing discovery rules is to eliminate the possibility of surprise at trial by permitting all relevant facts and information to be ascertained in advance thereof; (2) facts which have no bearing on the determination of the action on the merits are not subject to discovery; and (3) information is not discoverable when its sole purpose is to evaluate a case for the purpose of settlement.[86]

From the foregoing, it can be readily seen that the crux of the conflicting views lies in whether or not *pre-trial discovery of the existence and extent of defendant's liability coverage touches the merits of the plaintiff's cause of action so as to affect the amount of damages plaintiff sustained.*[87] The cases holding affirmatively[88] contend that employment of investigators, expert witnesses, photographers, and even the tak-

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[83]Roembke v. Wisdom, 22 F.R.D. 198 (S.D. Ill. 1958); Gallimore v. Dye, 21 F.R.D. 283 (E.D. Ill. 1958); McNelley v. Perry, 18 F.R.D. 360 (E.D. Tenn. 1955); McClure v. Boeger, 105 F. Supp. 612 (E.D. Pa. 1952); Orgel v. McCurdy, 8 F.R.D. 585 (S.D.N.Y. 1948); Di Pietruntonio v. Superior Court, 84 Ariz. 291, 327 P.2d 746 (1958); McKee v. Walker, 21 Conn. Supp, 168, 149 A.2d 704 (Super. Ct. 1958); Verrasto v. Grecco, 21 Conn. Supp. 165, 149 A.2d 703 (Super. Ct. 1958); Ruark v. Smith, 147 A.2d 514 (Del. Super. Ct. 1959); Brooks v. Owens, 97 So. 2d 693 (Fla. 1957); Layton v. Cregan & Mallory Co., 263 Mich. 30, 248 N.W. 539 (1933); Jeppesen v. Swanson, 243 Minn. 547, 68 N.W.2d 649 (1955); State v. Second Judicial Dist. Court, 69 Nev. 196, 245 P.2d 999 (1952); Goheen v. Goheen, 9 N.J. Misc. 507, 154 Atl. 393 (Cir. Ct. 1931); McGrath v. Vaccaro, 270 App. Div. 948, 62 N.Y.S.2d 244 (2d Dep't 1946); Peters v. Webb, 316 P.2d 170 (Okla. 1957); Bean v. Best, 76 S.D. 462, 80 N.W. 2d 565 (1957).

[84]Brackett v. Woodall Food Products., Inc., 12 F. R.D. 4 (E.D. Tenn. 1951); Laddon v. Superior Court, 334 P.2d 638 (Cal. 1959); Superior Ins. Co. v. Superior Court, 37 Cal. 2d 749, 235 P.2d 833 (1951); Demaree v. Superior Court, 10 Cal. 2d 99, 73 P.2d 605 (1937); People ex rel. Terry v. Fisher, 12 Ill. 2d 231, 145 N.E.2d 588 (1957); Maddox v. Grauman, 265 S.W.2d 939 (Ky. 1954).

[85]If an automobile liability policy evidences a contractual relation which inures to the benefit of any person who might be negligently injured by the insured as completely as if such person had been specifically named in the policy, as held in the Superior case, supra note 84, it would seem that the beneficiary of such contract must, as a condition precedent to bringing suit against the insurer, prove the negligence of the insured.

[86]The argument is also made that discovery rules are to secure a just, speedy and inexpensive determination of every action, but that the word "determination" refers to the disposition of an action in some manner over which a court has control, hence, that "determination" does not encompass settlement. Benal Theatre Corp. v. Paramount Pictures, 9 F.R.D. 726 (N.D. Ill. 1947). Moreover, the type of settlements over which a court would have control involve claims of infants and incompetents.

[87]In People ex rel. Terry v. Fisher, 12 Ill. 2d 231, 238, 145 N.E.2d 588, 593 (1957), the court declared: "Plaintiff with serious injuries would settle a substantial judgement against a defendant of modest means for a fractional sum, simply because he has no knowledge of any additional rights against the insurer."

The latter argument completely ignores the proceeding supplementary to judgement whereby examination of the judgement debtor may be had regarding his ability to pay which includes claims the judgement debtor may have against third parties.

[88]See, e.g., People ex rel. Terry v. Fisher, supra note 87.

ing of depositions, touches the merits of plaintiff's cause of action and, therefore, is material in evaluating one's case for the purpose of settlement. If this be so, may not one argue that a defendant in an action for damages, whether tort or contract, be made to furnish a financial statement,[89] even though he be an individual, partnership, or corporation? The cases supporting the negative contend that the purpose of discovery is to assist the parties and the court in disposing of the litigation, *not* to supply information for the personal use of the litigants.[90] Moreover, the affirmative argument appears to correlate the plaintiff's damages to the defendant's ability to pay,[91] or to put it in another way, as to how much the traffic will bear.

The law with respect to damages in the vast majority of jurisdictions has been stated as follows:

> The fundamental principle of the law of damages is that one injured by a breach of a contract or by a wrongful or negligent act or ommission shall have fair and just compensation commensurate with the loss sustained in consequence of the defendant's act which gives rise to the action.[92]

In other words, the damages awarded should be commensurate with the injury sustained.[93] To advance the theory that damages for personal injury should be measured by the defendant's ability to pay is to introduce a startling concept in the field of jurisprudence, no matter how subtle the approach.

## Conclusion

In states having direct action statutes,[94] discovery by the plaintiff of the existence of insurance coverage is proper and warranted by controlling state and federal discovery rules. By legislative mandate, the plaintiff here has a discoverable interest. In states having statutes which permit an action against the insurer only after a final judgment has been obtained against the insured,[95] no discoverable interest exists in advance of trial. In such states the plaintiff may obtain the desired information in a proceeding supplementary to judgment,[96] hence pre-trial discovery of insurance coverage is improper and unwarranted under existing discovery procedure. As a practical matter, whenever an accident is reported, the insurer, in most cases, takes over the investigation, interviews the witnesses, if any, and prepares the case for trial. The insured must cooperate from the very beginning or hazard a disclaimer by the insurer. Thus, the plaintiff may acquire knowledge of existing insurance through: (1) disclosure by the insured; (2) an offer to settle in advance of trial by the insurer; (3) at a pre-trial hearing; or (4) by the character and conduct of the defense during trial.[97] Disclosure of the policy limits in advance of trial is difficult to justify. It can have no possible bearing on the issue of defendant's negligence even when ownership, agency or control are in dispute. Defendant's ability to pay or the evaluation of plaintiff's cause have never been within the purview of discovery procedure. While the rules should be given a liberal construction, they should not be prostituted for purposes not within the de-

[89] See, e.g., McClure v. Boeger, 105 F. Supp. 612 (E.D. Pa. 1952).

[90] See, e.g., Balazs v. Anderson, 77 F. Supp. 612 (N.D. Ohio 1948).

[91] See notes 39, 43, 48 and 57 supra.

[92] 15 Am. Jur. Damages § 12, at 400 (1938).

[93] Miller v. Robertson, 266 U.S. 243 (1924); Hanna v. Martin, 49 So. 2d 585 (Fla. 1951).

[94] See notes 13 and 14 supra. The situation in Villars v. City of Portsmouth, 100 N.H. 453, 129 A.2d 914 (1957), is analogous. Here the Supreme Court of New Hampshire, in a declaratory judgement action, held that the defendant city should produce the insurance policy upon request of the plaintiff. It is pointed out in this case that under the common law the city would not be liable, but by statute, if a policy of liability insurance had been procured by defendant city, liability might exist to the limit of the policy.

[95] See notes 19, 20 and 47 supra.

[96] See note 47 supra.

[97] In states having compulsory insurance statutes in force the plaintiff will have knowledge of the existence of insurance coverage and at least the minimum of the policy limits as therein prescribed. See, e.g., Teller v. Clear Service Co., 9 Misc. 2d 495, 173 N.Y.S.2d 183 (Sup. Ct. 1958). Here, plaintiff applied for preference at a pre-trial hearing under pre-trial procedure adopted by the Justices of the Appellate Division for the First Department on January 5, 1958. The court declared: "Refusal by a defendant to disclose the amount of insurance or reinsurance carried or the concealment of any facts concerning the financial standing of the defendant or, where there is a prima facie case and the injuries are severe (though there may be a disputed issue of liability), the offer of a mere nominal sum are deemed failures on the part of the defendant to cooperate and negotiate in good faith to reduce the negligence case load. Such conduct is held to warrant the granting of a preference or the taking of such other action as may be appropriate." Id. at 497, 173 N.Y.S.2d at 185. The defendant here was the corporate owner of a fleet of two taxicabs.

clared and recognized objectives for which they were adopted.[98]

It follows then that in the absence of a direct action statute, or where ownership, operation or control are not in dispute, pre-trial discovery of insurance coverage should be prohibited. Where ownership, operation or control are in dispute, or where a direct action or analogous statute is involved, pre-trial discovery should be limited to establishing the fact that insurance coverage existed.

The contention that compelling disclosure of insurance coverage in advance of trial violates defendant's constitutional rights[99] was decided adversely to defendant in *People v. Fisher.*[100] Furthermore, the Supreme Court of the United States held in *Watson v. Employer's Liab. Assur. Corp.,*[101] that Louisiana's direct action statute[102] did not contravene the equal protection and due process clauses of the Federal Constitution.

Discovery is a matter of procedure and the Supreme Court of the United States has held that a state has full power over remedies and procedure in its own courts, and can make any order it pleases in respect thereto, provided that substance of right is secured without unreasonable burden to parties and litigants.[103] It, would appear, therefore, that the objection of unconstitutionality is not well taken.

Judicial legislation regarding discovery of insurance coverage appears to have reached its peak in the *Fischer* case. It is noteworthy that with the exception of the *Laddon* decision,[104] subsequent cases[105] have held that discovery must remain within the limits of relevancy and materiality to the issues raised by the pleadings. This view is eminently sound.

Assuming, but not conceding, that discovery of insurance coverage in advance of trial would serve the public interest, nevertheless, any change, albeit desirable, should be effectuated by the proper rule-making power, and not by judicial fiat.

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[98]The Minnesota court, in Jeppesen v. Swanson, 243 Minn. 547, 562, 68 N.W.2d 649, 658 (1955), stated: "Under the guise of liberal construction, we should not emasculate the rules by permitting something which never was intended or is not within the declared objects for which they were adopted. Neither should expedience or the desire to dispose of lawsuits without trail, however desirable that may be from the standpoint of relieving congested calendars, be permitted to cause us to lose sight of the limitations of the discovery rules or the boundaries beyond which we should not go. If, perchance, we have the power under the enabling act to extend the discovery rules to permit discovery of information desired for the sole purpose of encouragting or assisting in negotiations for settlement of tort claims, it would be far better to amend the rules so as to state what may and what may not be done in that field than to stretch the present discovery rules so as to accomplish something which the language of the rules does not permit."

[99]Williams, Discovery of Policy Limits, 26 Ins. Counsel J. 225 (1959).

[100]12 Ill. 2d 231, 145 N.E.2d 588 (1957).

[101]348 U.S. 66 (1954).

[102]La. Rev. Stat. § 655 (1950). See note 13 supra and accompanying text.

[103]York v. Texas, 137 U.S. 15 (1890).

[104]See notes 1-3 supra.

[105]Roembke v. Wisdom, 22 F.R.D. 198 (S.D. Ill. 1958); Gallimore v. Dye, 21 F.R.D. 283 (E.D. Ill. 1958); Di Pietruntonio v. Superior Ct., 84 Ariz. 291, 327 P.2d 746 (1958); McKee v. Walker, 21 Conn. Supp. 168, 149 A.2d 704 (Super. Ct. 1958); Verrastro v. Grecco, 21 Conn. Supp. 165, 149 A.2d 703 (Super. Ct. 1958); Ruark v. Smith, 147 A.2d 514 (Del. Super. Ct. 1959); Brooks v. Owens, 97 So. 2d 693 (Fla. 1957); Peters v. Webb, 316 P.2d 170 (Okla. 1957).

*Editor's Note:* The case of *Hurt v. Cooper,* 175 F. Supp. 712, was decided by District Judge Swinford, in Kentucky, on August 7, 1959. Without discussing the opposing position, Judge Swinford ordered the defendant to answer the following interrogatories:

"1. Was there a policy of liability insurance in force and effect on the vehicle being driven by Jacob Cooper on the date of the accident about which this suit has arisen?

"2. If your answer is yes to question No. 1, then state the name and address of the insuring company, and the limits of liability of said policy.

"3. If your answer to question No. 1 is that you do not know, then obtain the information, and if any such insurance was in effect, then obtain complete copies of the policy and deliver same to plaintiffs' attorney for purposes of discovery."

# When Is An Architect or Engineer Liable?

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## *Historical*

UNDER THE CODE of Hammuribi, the Babylonian justice for a builder was both swift and severe. Death was required "of a builder's son for a house being so carelessly built as to cause the death er of the owner's son".[1] The Romans continued the vogue of *lex talonis.*[2] From the monument of Babylonian law the pendulum swung to the furthest extreme in the English law of no liability. So drastic a change required nearly four thousand years. The early British barristers developed a rule that an architect's or engineer's duty is not merely ministerial but that he is in a position of an arbitrator between the parties so that he could not be held liable for the result of his decisions so long as it was free of fraud or collusion. Everywhere there was a refusal to give either grounds or reasons for his decisions, it was held no aid to the plaintiff, the court holding that this super arbitrator was not required to give either reasons or opinions.[3]

The early decisions in America followed the English rule, regarding the architect or engineer, and holding the quasi-arbitrator not liable for negligence in making decisions.[4] In modern times the pendulum is dence; Abritration and Award, Par. 100, pg. 928. slowly swinging away from the English rule and our early cases. The architect's or engineer's decision is binding on all parties but liability is governed by our common law rules of negligence. In at least three general classes of cases, an architect or engineer has been held liable for his negligence.

## *Responsibility for Defects Attributed to Plans and Specifications*

An architect, in preparation of plans, drawings and specifications, owes to his employer the duty to exercise his skill, ability, judgment and taste both reasonably and without neglect.[5] As to the measure of damages for defects of construction attributable to the lack of skill either in preparations of plans or supervising of construction, there are two distinct rules depending on the character of the defect rather than different jurisdictions. If the defects can be remedied, this cost is the measure of damage.[6] Where the structure cannot be corrected without unreasonable or disproportionate expense, the measure of damages is the difference between the value of the building as designed and built

[1]Encyclopedia Britannica (14th Edition), page 864.

[2]"Like for Like—Punishment of an injury by an act of same kind—Eye for Eye", Black's Law Dictionary (3rd Edition) page 1781.

[3]*Stevenson v. Watson* (1879) LR4CP Div. 148—40 LTR (NS) 485.

[4]See "Immunity of Arbitrators", 3 Am. Jurisprudence; Abritration and Award, Par. 100, pg. 928.

[5]*Looker v. Gulf Coast Fair*, 203 Ala. 42, 81 So. 832; *Bayshore Development v. Bondfoey*, 75 Fla. 455, 78 So. 507; *Block v. Happ*, 144 Ga. 145, 86 S.E. 316; *Trunk and Gordon v. Clark*, 163 Iowa 620, 145 N.W. 277; *Kortz v. Kimberlin*, 158 Ky. 566, 165 S. W. 654; *Simpson Bros. Corp. v. Merrimac Chemical Co.*, 248 *Mass.* 346, 142 N.E. 922; *Chapel v. Clark*, 117 Mich. 638, 76 N.W. 62, 72 Am. St. R. 587; *Dysart-Cook Mule Co. v. Reed & Heckenlively*, 114 Mo. App. 296, 89 S.W. 59; *Major v. Leary*, 241 App. Div. 606, 268 N.Y.S. 413; *White v. Pallay*, 119 Ore. 97, 247 P. 316; *Presnall v. Adams* (1919, Texas Civ. App.) 214 S.W. 357; *Shipman v. State*, 43 Wis. 381. This rule is also followed in Canada, *Couchon v. MacCosham*, 19 D.L.R. 708. Because of the contractual relation with the owner, a principal-agent relationship exists. 6 C.J.S. Architects, Par. 7 (1937).

[6]*Schreiner v. Miller*, 67 Iowa 91, 24 N.W. 738; *Truck and Gordon v. Clark*, 163 Iowa 620, 145 N. W. 277; *Barraque v. Neff*, 202 La. 360, 11 S. 2d 697; *Dysart-Cook Mule Co. v. Reed & Heckenlively*, 114 Mo. App. 296, 89 S.W. 591; *Swartz v. Kuhn*, 71 Misc. 149, 126 N.Y.S. 568; *Cheaverini v. Vail*, 61 R. I. 117, 200 Atl. 462.

and the value it would have had, if it had been properly constructed and designed.[7] The test is if the defect is so intimately connected with the body of the structure, or is so inherent in some permanent part of the structure that it cannot be remedied at reasonable expense or without tearing it down and rebuilding it, then proper measure of damages is the difference between the value of the building now and the value it would have had if it had been made upon correct plans and specifications.[8]

Complications arise where there are two causes contributing to the defect. The architect is only liable for his part thereof, but he is not allowed anything for the preparation of the plans as he failed to supply proper ones.[9]

Efficiency of an architect in the preparation of plans and specifications is tested by the rule of ordinary and reasonable skill usually exercised by one in the profession.[10] But an architect undertaking to prepare plans does not imply or guarantee either a perfect plan or satisfactory result.[11]

These general principals attributed to the error in the plans or specifications of the architect usually occur when: 1. The fixtures are not adequate for their intended use: 2. The roof, floors or walls become cracked[12], buckle or collapse[13]; 3. The foundation is not sufficient to provide adequate support[14]; or 4. The waterproofing is not sufficient to prevent leaks or seepage. Occasionally the owner claims that the architect is responsible for defects in the work which are alleged to have been caused by improper or unsuitable materials prescribed in the specifications. These are usually claimed as offset or counter-claims where the architect sues the owner for fees for preparation of plans and specifications.[15] But where there is error or oversight in the preparation of the plans necessitating repairs, nevertheless they could not be made with unnecessary expense or in an extravagant form and recover the amount of the disbursements[16] where an architect was employed to complete a building according to the plans and specifications of a preceding architect. The supervising architect was not responsible to the owner for errors or mistakes in such plans nor could he be held responsible if the quality of the materials and workmanship prescribed did not meet the approval and expectation of the owner.[17] The supervising architect was required to complete the building in a reasonably careful and skillful manner and in substantial compliance with the plans and specifications of the original architect who prepared them.

### *Liability For Personal Injury or Death Caused by Improper Plans or Designs or Specifications*

In early cases frequently it was declared that no cause of action in tort could arise from a breach of contract unless there was between the defendant and the injured plaintiff what was termed "privity of contract".[18] In more modern times this doctrine has been limited in some jurisdictions, modified in many states, and rejected by others.[19] The court in New York[20] held a manufacturer of an inherently dangerous Buick automobile liable for injuries to remote users. Dean Prosser[21] declared, "There is no visible reason for any distinction between the liability of one who supplies a chattel and one who erects a structure."

[7] *Bayshore Development Co. v. Bondfoey*, 75 Fla. 455, 78 So. 507; *Truck and Gordon v. Clark*, 163 Iowa 620, 145 N.W. 277.

[8] 3 Am. Jur., Architects, par 20.

[9] *Boyd v. Foster*, 202 Ill. App. 251; *Cauchon v. MacCosham* (Can.) 28 West LR 500, 19 DLR 708, 25 A.L.R. 2d 1085.

[10] *Am. Surety Co. v. San Antonio Loan & Trust Co.*, 101 Tex. 63, 104 S.W. 1061, 22 L.R.A. (N.S.) 364, 130 Am. St. Rep. 803.

[11] *White v. Pallay*, 119, Ore. 97, 347 P. 316.

[12] *Hill v. Polar Pantries*, 219 S.C. 263, 64 S.E. 2d 885, 25 A.L.R. 2d, 1080.

[13] *School District of King Co. v. Josenbaus*, 88 Wash., 624, 153 P. 326.

[14] *White v. Pallay*, 119 Ore. 97, 347 P. 316.

[15] *Stewart v. Boehme*, 53 Ill. App. 463.

[16] *Bayshore Development Co. v. Bondfoey*, 75 Fla. 455, 78 So. 507, L.R.A. 1918D 889.

[17] *May v. Howell*, 32 Del. 221, 121 Atl. 650.

[18] 38 Am. Jur. 662, Negligence, Par. 21.

[19] 13 A.L.R. 2d 191; 58 A.L.R. 2d 865 and 165 A.L.R. 569: Manufacturer's liability for negligence causing injury to person or damage to property, of ultimate consumer or user."

[20] *MacPherson v. Buick Motor Co.*, 217 N.Y. 382, 111 N.E. 1050, L.R.A. 1916F, 696. Analysis of decisions in which a remote user has recovered in tort from a manufacturer, supplier or contractor for example are: sudden collapse of an imperfectly constructed scaffold—*Delvin v. Smith*, 89 N.Y. 470; Faulty erection of concrete ceiling—*Adams v. White Construction Co.*, 299 N.Y. 641, 87 N.E. 2d 52; Breaking of poorly made handle on coffee urn, *Hoening v. Central Stamping Co.*, 273 N.Y. 485, 6 N.E. 2d 415; Explosion of defectively manufactured soda bottle—*Smith v. Peerless Glass Co.*, 259 N.Y. 292, 181 N.E. 576; Explosion of an electric transformer improperly packed—*Rosenbrock v. General Electric Co.*, 236 N.Y. 227, 140 N.E. 571. When chattel was a type inherently dangerous to human safety, *Huset v. J. I. Case*, 120 Fed. 865.

[21] Prosser on Torts (2d Ed., 1955) Par. 85, page 517; 13 A.L.R. 2d 191 Restatement Torts, Par. 385.

Pennsylvania was one of the first courts to follow this line of reasoning and held, "There is no reason to believe that the law governing liability should be, or is, in any way different where real structures are involved instead of chattles. There is no logical basis for such a distinction. The principle inherent to liability cannot be made to depend merely upon the technical distinction between a chattle and a structure built upon the land."[22] Architects, engineers and contractors should be liable to persons with whom they have no privity of contract for injuries sustained, even after the erection of a dangerous structure under the same principles of negligence applicable to manufacturers.[23] Some authorities hold that the proper test of liability is whether the manufacturer, architect or builder should recognize that his failure to exercise reasonable care involves an unreasonable risk of causing substantial bodily harm to those gainfully using the chattle or structure in a manner and for a purpose for which it was created.[24] Indemnity from the claims of third persons is due a tortfeasor who has a contractual right to expect his joint tortfeasor to do that, which if it had been done as agreed, no injury would have resulted.[25] "Thus an architect or engineer in preparing plans and specifications for the construction of a building under employment by the owner, is following an independent calling, and is doubtless responsible for any negligence in failing to exercise the ordinary skill of his profession, which results in the erection of an unsafe structure whereby anyone lawfully on the premises is injured."[26]

"By undertaking professional service to a client, an architect impliedly represents that he possesses, and it is his duty to possess, that degree of learning and skill ordinarily possessed by architects of good standing; practicing in the same locality. It is his further duty to use the care ordinarly exercised in like cases by reputable members of his profession practicing in the same locality; to use reasonable diligence and his best judgement in the exercise of his skill and the application of his learning in an effort to accomplish the purpose for which he is employed."[27] But there are limitations on the duties of an architect. "The responsibility of an architect does not differ from that of a lawyer or physician. When he possesses the requisite skill and knowledge and in the exercise thereof has used his best judgment, he has done all that the law requires. The architect is not a warrantor of his plans and specifications. The result may show a mistake or defect, although he may have exercised the reasonable skill required."[28]

An architect was held not liable when he was employed by a school trustee to draw plans and specifications for a school building which met with the approval of the trustee, where a child fell over a wall onto a concrete floor. The alleged negligence was based on the absence of a guard rail.[29] The court laid great stress on the theory that a public officer invested with discretion, when exercising his judgment in matters brought before him is immune from liability to persons who may be injured as the result of an erroneous or mistaken decision, provided he acts within the scope of his authority and without either willfulness, malice or corruption.[30] The court held the architect was employed simply to draw plans and specifications for the school building; that the plans and specifications prepared were submitted to the trustee, discussed, changed, modified and corrected and finally approved; that thereafter the school was constructed according to the new plans and specifications. "It would be a strange rule of law which would excuse the act of the official in passing upon the plans and adjudging them sufficient and yet would hold the person who drew them liable in damages because of alleged incompetance."

The third classification involves those

[22] *Foley v. Pittsburg-Des Moines Co.*, 363 Pa. 1, 68 A, 2d 517. See also *George v. Sturgis*, 56 App. D.C. 364, 14 F. 2d 256. *Ford v. Sturgis*, 56 App. D.C. 361, 14 F. 2d 253, 52 A.L.R. 619, which was overruled *Hanna v. Fletcher*, 97 App. D.C. 310, 231 F. 2d 469, 58 A.L.R. 2d 847 "insofar as it stands for the general rule that a person injured by reason of a contractor's negligence cannot recover from the contractor if the injury occured after the product of his defective work was accepted by the party who engaged him." *Clemens v. Benzinger*, 207 N.Y.S. 539.

[23] *Person v. Cauldwell-Wingate Co.*, (2 Cir.) 176 F. 2d 237, 8 Syracuse Law Review 95, 55 Mich. Law Rev. 603.

[24] Restatement of The Law of Torts, Par. 385, page 395.

[25] *John Wanamaker v. Otis Elevator Co.*, 228 N.Y. 192, 126 N.E. 718.

[26] *Patter v. Gilbert*, 115 N.Y.S. 425, 196 N.Y. 576, 90 N.E. 1165.

[27] *Paxton v. Alameda County*, 119 Cal. App. 2d 393, 259 P. 2d 934.

[28] *Bayne v. Everham*, 197 *Mich.* 181, 163 N.W. 1002.

[29] *Sherman v. Miller Construction Co.*, 90 Ind. App. 462, 158 N.E. 255.

[30] 43 Am. Jur. 662, Negligence Par. 21.

cases where injury or death results to persons working on a structure when it collapses as a result of the architect's defective plans or designs. These cases arise before the building is completed. The two previous illustrative classifications arose after completion.

In an interesting and illustrative case the architect was held liable.[31] The plaintiff's intestate was employed by a contractor engaged in the erection of structural steel for a grandstand. Fatal injuries were sustained when he was struck by a steel column which fell because a wrong type bolt had been used to anchor it to concrete which had not hardened sufficient to bear the strain of the column. Judgment was rendered against the contractor who did the concrete work, the contractor doing the structural steel work and the architect, who was also supervising. The appellate court affirmed the judgement and liability of the architect. Liability could be predicated on his supervisory activities, namely his failure to notify the contractor engaged in the erection of structural steel of the true conditions, after authorizing and directing the placing of the anchor bolts in the drilled holes with their strength as supports wholly dependent on the resistance of the unhardened cement, or it could have been based on the defect of the original plans in which the type of anchor bolt to be used was not specified. The architect approved the detailed plans prepared by the contractor in which the improper type of bolt was specified. "For defects in the original plans and the approval of detailed plans arising from negligence on the part of the architect liability resulted." Where there is a latent or concealed defect resulting in injury, the liability results.[32]

### *Liability of Architect or Engineer for Improper Issuance of Certificate*

The American Institute of Architects has zealously fought to preserve the high standing of all architects in the courts of our nation and especially to preserve the immunity which its members have enjoyed for centuries. The members of this outstanding association are loyal and fraternal in the defense of their members, and if you try to prove lack of good faith, fraud, failure to exercise skill and care or even simple negligence you would be confronted by a most difficult situation. Your status would be analogous to a plaintiff in a malpractice case who wishes to produce a disinterested doctor. In all the early cases, and usually, the architect's certificate is agreed to be conclusive as between the parties and as he is acting in a dual capacity and quasi-arbitrator there is no resulting liability.[33] The reasoning of these early cases was based on the contract wherein the plaintiff owner and the contractor had both agreed that the architect would be the sole arbitrator.[34] Then the courts held that an architect who was negligent in approving a contractor's claim for a greater amount than was actually due, was liable to the owner for the excess payment made in reliance on the certificate but not for the cost of completing the building in accordance with the contract terms.[35] Where defects in construction were discovered after a supervising architect had given the final certificate, evidence of such defects might give rise to a claim for damages in recoupment in the architect's action for his services, but a showing of negligence did not constitute a complete defense to the claim for compensation.[36] Architects being skilled persons are held to a higher degree of care than unskilled persons and if they fail in the duty owed either in the preparation of the plans or in the supervision of the work, liability would result for the damages proved by the owner.[37]

Where a roof collapsed after an architect, who prepared plans and supervised work, gave his final certificate, the court rejected the theory that progress payments were merely authorizations for the contractor to draw proportionate parts of his pay. The fact that the condition which caused the collapse was known to the owner was held not to preclude recovery, since the owner was entitled to rely on the sufficiency of the construction as certified by the architect. The certificates given during the progress of the work were each evidence

[31] *Clemens v. Benzinger,* 211 App. Div. 586, 207 N.Y.S. 539.

[32] *Campo v. Scofield,* 301 N.Y. 468, 95 N.E. 2d 802.

[33] 42 L.R.A. (N.S.) 282, Anno. Cases 1913E653. Also Immunity of Arbitrators See 3 Am. Jur., Arbitration, Par. 100.

[34] *Corey v. Eastman,* 166 Mass. 279, 44 N.E. 217, 55 Am. St. Rep. 401, *Wilder v. Crook,* 250 Ala. 424, 34 So. 2d 832.

[35] *Bump v. McGrannahan,* 61 Ind. App. 136, 111 N.E. 640. See the early case (1899) *Lasher v. Colton,* 80 Ill. App. 75.

[36] *Lindberg v. Hodgen,* 89 Misc. 454, 152 N.Y.S. 229.

[37] *Pierson v. Tyndall* (1894, Texas) 28 S.W. 2d 232.

that the work had been satisfactorily completed by the contractor.[38]

A supervising architect acting fraudulently or in collusion with one of the parties in issuing payment certificates was held liable for all resulting damages. There is a question of fact presented for architects' negligence in issuing a certificate, but a false certificate based on fraud or collusion renders the architect liable for all damages as he owes owner a fiduciary duty of both loyalty and good faith.[39]

In a well reasoned case it was held that where the contract required the contractor to submit to the architect evidence that payrolls and materials bills had been paid before issuing a certificate of substantial completion, it was negligence, which resulted in liability, if the architect failed to require such evidence and by issuing his certificate released the retainage. The surety had a right of subrogation, since it was entitled to protection. The court rejected the contention that the architect could not be held liable because there was no privity of contract between the architect and the surety. The duty to ascertain that the contractor had paid the bills was owed both to the building owner and the surety, for whose mutual protection the retainage was provided. The failure of the architect to exercise due care and diligence in carrying out his duties might result in loss to the surety, when he undertook the performance of an act which, if negligently done, would result in loss, so that the law imposed upon him the duty to exercise due care to avoid such loss even in the absence of a contractual relationship. The fact that surety had taken no steps to ascertain that outstanding bills for labor and materials were being paid by the contractor was held not to charge it with contributory negligence, since it had the right to assume that the retainage would not be released until the contract had been fully performed.[40]

Thus we see that either an architect or an engineer may be liable in these three general classes of cases:

1. Responsibility of one acting for defects or insufficiency of work attributable to plans.

2. Liability for either personal injuries or death from improper plans or designs; and

3. For improper issuance of certificate either for progress payments or for the final estimate.

We should like to mention other classes of cases involving the liability of these professions, but allotted space only permits discussion of three.

Liability coverage for the architect or engineer now seems a necessity for these professions, just as it has become advisable for attorneys, doctors, dentists and other professional people. A claim could be quietly and satisfactorily settled by an insurance adjuster, but a law suit against either an architect or an engineer, in addition to the financial loss, might ruin his future business reputation with his public.

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[38] *School District v. Josenhans,* 88 Wash, 624, 153 Pac. 326.

[39] *Palmer v. Brown,* 127 Cal. App. 2d 44, 273 P. 2d 306.

[40] *State of Miss. for the use of National Surety Corp. v. Malvaney, et al,* (Miss.) 72 So. 2d 424, 45 A.L.R. 2d 1212. (The rights accruing to the surety date back to the time the bond was executed. *Canton Exchange Bank v. Yazoo Co.,* 144 Miss. 579, 109 So. 1. *Derby v. U. S. F. & G. Co.,* 87 Or. 34, 169 Pac. 500. *Sou. Surety Co. v. Schlesinger,* 114 Ohio St. 323, 151 N.E. 177, 45 A.L.R. 371. Surety's right to retainage is protected under the doctrine of equitable subrogation. *Ohio Cas. Co. v. Galvin,* 222 Iowa 670, 269 N.W. 254, 108 A.L.R. 1036. Paying surety has right to retained percentage and superior to those of a lending bank which is a volunteer and a common creditor. *Am. Bank v. Langston,* 180 Ark. 643, 22 S.W. 2d 381. *Haverstick v. Sheirich,* 304 Pa. 437, 115 Atl. 859, 76 A.L.R. 912.)

The famous *MacPherson v. Buick Motor Co.,* 217 N.Y. 382, 111 N.E. 1050 overruled the early theory of *Winterbottom v. Wright,* 10 Mees & W. 109, which had been cited since 1842, which held there was no liability of a contracting party to one with whom he had no privity. Exceptions had been recognized to this general rule either where the seller of chattles knew that it was dangerous for its intended use or if the chattle was of a type inherently dangerous to human safety. See *Huset v. J. I. Case Threshing Machine Co.,* 120 Fed. 865 (8 Cir.); *Lewis v. Terry,* 111 Cal. 39, 43 Pac. 398 and *Schubert v. J. R. Clark Co.,* 49 Minn. 331, 51 N.W. 1103.

In the *Malvaney* case the defendant unsuccessfully raised five separate defenses and Justice Holmes decided all of these theories against the architect:

1. There was no privity of contract between the architect and the surety and therefore no duty was owed the surety and no damages could be recovered regardless of negligence.

2. That retainage is not a trust fund and therefore there is no lien thereon either legal or equitable for the benefit of the surety.

3. If the surety had a cause of action, it did not keep up with the project and architect was entitled to the defense of contributory negligence (as in auto cases in Mississippi).

4. That by agreement of the parties the architect was the sole judge of what evidence should be required that the material bills were paid and he acted in a quasi judicial capacity.

5. If the surety had any rights under equitable subrogation it did not accrue until either the date the contractor gave notice of his default or when the surety actually paid the outstanding bills for materials.

# Competition in the Multiple-Line Insurance Business*

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THE slogan "competition is the life of trade" has become so imbedded in our thinking about the free-enterprise system that it is necessary from time to time to demonstrate that, under certain circumstances, open competition in the insurance business may be harmful if it does not actually promote the death of trade.

This is a continuous educational undertaking because of recurring inquiries such as the one now engaging the attention of a special committee of the United States Senate. Historically speaking, the issue has been raised, debated and presumably decided several times. But it simply refuses to remain quiescent because the notion keeps popping up that the insurance business is like other businesses and, therefore, must be subjected to the same legal restrictions against monopolistic practices that are prescribed for business in general.

Congress, under Public Law 15, which permits state regulation of the insurance business, and the several state legislatures that have passed regulatory laws supplementing Public Law 15, have been careful to specify that competition in the insurance business shall not be inhibited but, rather, that it must be encouraged. Since insurance *is* unique, the basic question is how much and what kinds of competitive activity are to be fostered and at what point the law or regulatory authority must be invoked to prevent conduct that is unfair, disruptive or injurious.

I shall attempt to establish which forms of competition in the insurance business are healthy and which are not. In doing so I shall begin with those areas where some restraints seem to be required. These have to do, generally, with four phases of the insurance business:

1. Rating of individual pieces of business.
2. Competition for the services of independent producers of business.
3. Selective methods aimed at writing the so-called "preferred" classes of business and
4. Various unsound practices that tend to weaken the structure of the business or to bring it into disrepute.

Let us briefly examine each of these items.

1. *Rating of business.* The essence of the insurance transaction is this:

> The insured, exposed to a specified peril or group of related perils, transfers to the insurer the uncertainty that he may become the victim of a substantial economic loss by accepting, instead, a relatively small certain outlay in the form of a *premium*.
>
> The insurer, in turn, accumulates many of these individual *uncertainties* and by a process of underwriting and good management produces a condition closely approximating *certainty*.

The essential element of the transaction is the premium paid for protection. In the aggregate these premiums must be sufficient to cover the losses and reasonable expenses of the insurer and to permit it to retain a modest underwriting profit—this is the test of *adequacy*. But premiums must not impose an unnecessarily severe burden upon insured—this is the test of

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*reasonableness:* and they should be equitable so that each insured contributes fairly according to his hazards—this is the test of fair *discrimination.*

Here we encounter an important point: At the time insurance is sold neither insurer nor insured knows exactly what the cost of protection for the individual piece of business will be. This can only be ascertained as the transaction runs its course and it may not be fully known for years if there is any element of deferred liability as is the case where claims are litigated or are payable in installments extending over a long period of time. Couple with this unknown factor, the possibility that a particular piece of business may not produce any losses at all or only a comparatively few minor losses and it is obvious that, as regards the individual insured, there is a great temptation for the insurer to adopt an optimistic attitude and to accept a low premium for insurance protection.

Imagine, then, what would happen if there were no regulation of rates and competition were permitted to run rampant. In the heat of competitive bidding, rates, inevitably, would be depressed *below the level of adequacy.* In the long run this would be disastrous to the smaller and less financially secure insurers and many insured might discover, when losses occured, that their insurance protection, was impaired or actually worthless. And even the larger and stronger insurers would suffer, because their success demands that rates shall be adequate, not perhaps for this year or next year, but generally adequate over a period of time. Otherwise, their underwriting operations will produce an uninterrupted drain upon their financial resources and this could not be tolerated indefinitely.

So unrestrained competition in rating is bad for insured and insurer alike. How can this adverse condition be avoided? *Obviously by lessening competition to some extent.*

In the insurance business, the process of transmuting uncertainties into a kind of certainty involves the use of a mathematical principle known as the *law of large numbers.* This law is utilized to ascertain, largely from past experience, what may be anticipated to be the pattern of occurrence of future losses. As its name implies, it requires the use of a large mass of homogeneous statistical data for its application—the larger the better. But the important thing is that rates, predicated upon this large mass of information, do provide a welcome guide for the appraisal of individual pieces of business because they represent the future losses that reasonably may be expected to occur *on the average.* It is as if a solid floor were constructed to mark the point where inadequacy becomes a danger, at the spot where only a bottomless pit had existed before.

The operations of a single insurer, no matter how extensive they may be, are insufficient to allow the resulting statistical experience to determine accurate rates for all the variations of hazard that will be encountered in rating individual pieces of business. Cooperation must be authorized, therefore, so that those insurers that are likeminded in this matter may agree upon

a. general insuring clauses,
b. standard classifications of business,
c. common underwriting rules and
d. uniform procedures for compiling and pooling statistical experience as a basis for rates.

This privilege is particularly important for insurers of modest size.

Here we encounter a real dilemma: how to foster this essential cooperation without running counter to the requirement that competition shall not be completely eliminated.

It is obvious that while reasonable independence of action must be permitted individual insurers that do not care to conform, the solid core of insurers that accept cooperative rate-making must have reasonable protection; else they will not be able to resist competitive pressures and the point may be reached where cooperative rate-making is no longer feasible. When it breaks down and every insurer attempts to make its own rates,

> the necessary statistical data for the application of the law of large numbers cannot be assembled because homogeneity will be sacrificed,
>
> no solid floor under rates can exist because there will be no comprehensive measurement of hazards to serve as a warning signal and
>
> a condition of utter chaos and anarchy becomes inevitable.

If this is regarded as a wild statement, let the doubter take an historical look at the conditions bred by the state anti-compact laws of the late eighteen hundreds which demanded wide-open competition. I have

talked to men who experienced the unfortunate consequences of such legislation and I can appreciate fully why this noble experiment was abandoned by the states as unsound and unworkable.

2. *Remuneration of independent producers.* Some insurers produce business by utilizing the services of independent agents and brokers. The remuneration of the latter is in the form of *commissions* that are expressed as percentages of the premium volume and vary according to the type of business produced and the nature and extent of the services rendered. For insurers that obtain their business exclusively through this system, it is extremely important that contacts should be made and developed with many competent, properly equipped producers who are able to deliver satisfactory volume of well-diversified and profitable business. This, then, is another area of intense competition.

Whereas unrestrained competition in rate-making inevitably threatens the *adequacy* of rates, open competition in commissions tends to drive the cost of production beyond the point of *reasonableness*. If rates are adjusted to take care of the increased cost of production, they may become exhorbitant and thus constitute a competitive handicap for insurers utilizing this method of production. If rates are not so adjusted, the burden of increased cost will have to be absorbed by insurers and this ultimately will influence their opportunities for satisfactory underwriting results. Some sort of control of this situation would seem to be desirable.

The first idea that might occur to anyone is to make certain provision in the rates for production cost and then to permit economic considerations to do the regulatory job. If the rate provides only so many dollars and cents for production and this fact is known to the management of an insurer, why will this not serve to restrict commissions so that the insurer will be able to live within its budget?

Unfortunately, experience has taught us that this idea will not work. The intense drive of competition, inevitably, will force even the most reluctant and conservative management to exceed the amount of money available in the rate for production. Something more than this is required to stabilize commissions!

Here again the answer seems to be to permit those insurers that are so minded, to cooperate to regulate commissions. Such regulation would involve these steps:

a. The several lines of business present differing problems of production. Therefore, the maximum production allowance should be specified for each line. Presumably these factors would then be incorporated in the rates.

b. Producers are not all similarly qualified and do not all render the same services. It is necessary, therefore, to establish a schedule of *varied* commissions to assure fair treatment of individual producers.

c. Then there must be some formula to limit the number and location of each insurer's producers who receive preferential commissions and to restrict the allowances (other than commissions) that may be paid to producers.

With some such program, it may be possible for individual insurers to function without incurring excessive production costs. Otherwise, the sky will be the limit!

Of course, it will be impossible to secure universal acceptance of such an arrangement. As a result it will be difficult to maintain such a set of production rules in the face of competition from non-cooperating insurers. If the rules are reasonable (and they would have to meet specific tests established by some state regulatory authority), it would seem desirable to afford the cooperating insurers some sort of protection. The justification for this would be that, in the long run, insureds would receive the monetary benefit of any stabilization of commissions that might be achieved.

3. *Selective underwriting.* In every sector of the insurance field, underwriters, with a remarkable degree of unanimity, have classified business according to quality. In the top classes will be found business that is generally regarded as "preferred".

Naturally, the management of every insurer will extend itself to write as much business of this type as possible. Rates that are equitable should reflect superior quality where it exists so that, theoretically, all insurers should enjoy equal competitive opportunities. In practice, however, the managements of non-conformist insurers, in their intense desire to build select portfolios, may feel impelled to employ such devices as fancy commission deals and various rating gimmicks to attract preferred business. So that in this situation there is likely to be a wild scramble for business with no holds barred.

But the real problem arises when the non-conformist insurer takes the flat position that it is not interested in, and will not accept business in other than the preferred classes. This is a form of competition that poses a problem for private insurers as a whole. If every private insurer emulated the program of the selective insurer, there would be countless insureds who would be unable to obtain protection. This would never do because if it is to survive, the private insurance business must demonstrate that it can provide protection for business of all types except the comparatively few cases where any reasonable person would concede that the business is uninsurable.

Again, it would be wishful thinking to expect all insurers to accept a common pattern of behavior. It is reasonable to hope, however, that the activities of those insurers that employ the most restrictive underwriting practices will not be permitted to deflect the great bulk of serious-minded managements from their determination to make protection available to the widest possible distribution of business of all kinds.

4. *Miscellaneous undesirable practices.* We come, finally, to a great variety of practices that have bad competitive connotations.

The insurance business is essentially a conservative business; it is no place for charlatans, promotors and speculators seeking to make a fast buck by finding and exploiting loop-holes in the law. It is firmly based upon fundamental principles that cannot be ignored with impunity; it is no place for unwise experimentation by those who do not understand and respect these principles. It is a business where good-faith is essential and it must maintain an impeccable reputation if it is to merit public esteem.

It is with violations of these three precepts that we are now concerned. The following cases in point are mentioned by way of illustration: (a complete list would be a very long one).

1. Organization of insurers with improper and inadequate financing and incompetent or dishonest managements.

2. Creation of groups of insurers purposely conducting business by devious processes that almost defy comprehension and make adequate regulation difficult, if not impossible.

3. Transacting business within a state from outside the borders of the state to avoid taxation and local supervision and disciplines.

4. Rebating—the practice by which a producer, working on a commission, shares his remuneration with an insured and thus reduces the cost of the latter's protection.

5. Employment of tricky and misleading language in insurance contracts and subsequently taking advantage of these weasel words to avoid full payment of losses.

6. Use of deceptive advertising that misrepresents the service and protection the insurer has to offer.

7. Circulating untrue statements about the financial strength or reputation of a competitor.

8. Utilizing the insurer's financial resources for highly speculative ventures designed to benefit a few insiders without regard for the interest of anyone else.

It would seem axiomatic that competition arising out of these and similar unfair, dishonest and unsound practices should be prohibited.

But there are other forms of competition in the insurance business that are unquestionably beneficial and permit a healthy rivalry to flourish among insurers. These are so obvious that they need only be listed for the completion of the record. There are at least six such areas of salutary activity:

1. Building security to guarantee the obligations assumed by the insurer. In general, the insurer whose methods of conducting business and management of finances create a position of recognizable strength is in a preferential competitive position. Size is not the sole criterion; something more subtle is involved that makes obvious to all that the insurer posesses integrity and stability and is worthy of complete confidence.

2. Legitmate research to discover the broadest possible forms of protection. This involves the content coverage afforded by the insurer's contracts with

insured. All things being equal, the insurer that offers the most comprehensive protection in the simplest form will be favored.

3. Extension and improvement of service to insured. Here we are talking about such things as

   a. the completeness of the market provided by the insurer;

   b. the methods employed to bring the the insurer's facilities to the attention of insured;

   c. the ease with which the latter may avail themselves of these facilities;

   d. the accuracy and care exercised to classify and rate the insured's coverage and to make certain that it is adequate in the light of current values;

   e. the extent to which the insurer advocates and enforces measures calculated to prevent or to minimize losses;

   f. the accuracy of audits where premiums are based upon variable exposures;

   and most important of all

   g. the efficiency and competence with which the insurer investigates and adjusts losses when they occur.

4. Finding the most direct, efficient and economical methods of conducting the insurance transaction and coping with the tremendous volume of essential paper work that must be done.

5. Search for talent and maintenance of special methods of instruction designed to raise the professional standards and performance of management, personnel and producers.

6. Continued existence and development of insurers committed to different conceptions of operation, so that the insured always will have the widest possible choice of the vehicle he may select for his insurance requirements.

There can be little disagreement that activities of this character are advantageous and should be strongly encouraged.

I have limited myself to a rather elementary analysis of competition in the field of multiple-line insurance and have refrained from stating my views how curbs should be applied where they appear to be necessary. There we might easily become involved in controversy. Some of you might even disagree with me that some forms of competition are harmful. I do not believe, however, that there can be any difference of opinion on one final point. Eminent judges, on more than a few occasions, have declared that insurance business is vested with a public interest which is paramount. In dealing with competitive problems the proper solutions must be those that serve not only the comfort and convenience of insurance executives but the welfare of the public as well!

# What Law Governs Intrafamily Immunity?

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"CONFLICTS of Laws" principles originated long before the automobile age. Their purpose, broadly, was to ensure that a certain set of facts give the same legal result regardless of the "forum" where suit might happen to be brought. Thus, the forum seeks to apply the law of the state most concerned with the significant facts, or with the result, or perhaps according to the presumed intention of the parties. From the idea that transitory rights acquired in one state should be enforceable in others, developed the handy principle that the locus of the occurrence of facts creating the cause of action should determine all "substantive" questions. Sometimes this makes sense. In the field of automobile accidents, however, sometimes it doesn't.

The automobile has severely tested conflicts principles, and has shown the fallacy of oversimplification in the conflicts field. In particular, families travel together readily throughout the states and have accidents far from home and, especially when other vehicles are involved, perhaps far from a still different state where the trial might be held. The majority of states bar the right of one spouse to sue the other in negligence,[1] and some similarly restrict the right of other members of a family household. What state law is to determine their rights to sue each other? Since the questions of immunity between spouses and that between other members of a family unit are similar, they will herein be considered together.

In *Haumschild v. Continental Casualty Company*, 7 Wis. 2d 130, 95 N.W. 2d 814 (1959), the Wisconsin Supreme Court recently grappled anew with the problem of conflicts in the law of intrafamily immunity from negligence liability. Plaintiff and defendant were married and lived in Wisconsin. (The marriage was later annulled, but this did not affect the decision.) Plaintiff was injured in California while riding in a truck driven by her supposed husband. She sued him in Wisconsin, where there is no tort immunity between husband and wife. Under California law, there is such immunity (though not among the rest of the family). The trial court dismissed the action, ruling that the immunity question was a substantive matter governed by California law (and that plaintiff was estopped from asserting the invalidity of her marriage). The Wisconsin Supreme Court reversed, holding that the law of the *domicile* (Wisconsin) should apply in determining incapacity to sue based on family relationship. The court had to overrule at least six of its prior decisions applying the law of the place of injury and also to depart from the rule of the Restatement, Conflict of Laws, adopted to establish uniformity in the field. It observed that the restatement is currently being revised and that this particular point would undoubtedly be considered.

Many states do cling to the idea that spousal or intrafamily immunity is simply a substantive question governed by the law of the place of the injury.[2] In other states the forum, itself, has a strong feeling of public policy against such law suits (especially between husband and wife) and so applies its own immunity not withstanding that the accident state

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[1] See 43 A.L.R. 2d 632-71.

[2] See, generally, 22 A.L.R. 2d 1248-60; e.g. *Bissonnette v. Bisonnette*, 145 Conn. 733, 142 A. 2d 527 (1958), wife living in Connecticut (no immunity) injured in massachusetts (immunity) had no cause of action, whereas in *Bogen v. Bogen*, 219 N.C. 51, 12 S. E. 2d 649 (1941), a wife living in Ohio (immunity) injured in North Carolina (no immunity) could enforce her North Carolina cause of action.

would allow the suit.[3] A third attitude is for a forum to regard the "disability to sue" existing in either the locus or the forum as procedural, and thus apply its own law. The state where the tort occurred might be considered merely to bar the remedy and not the underlying cause of action enforceable in the forum,[4] or on the other hand, the forum might refuse to enforce an admittedly valid foreign cause of action not on public policy grounds, but simply because of a local procedural bar.[5]

Various legal commentators criticized these views and argued that the law of the place of injury was both fortuitous and irrelevant to the issue of immunity because of family relationship, and that for the forum to apply its own law (apart from the matter of domicile) was not only unfair but would lead to "forum-shopping." Finally, in 1955, the Supreme Court of California broke away from the tide, agreed with the commentators, and announced that the law of the domicile would control all questions of intrafamily immunity. *Emery v. Emery,* 45 Cal. 2d 421, 289 P. 2d 218 (1955). Wisconsin, finding the arguments unanswerable, has fallen in step with what it calls a "trend."[6]

A sound approach to the conflicts question would seem to be initially to decide what is the real basis for the intrafamily or spousal immunity. The next step is to consider which state is most vitally concerned with the problem.

Theoretically, the fact of liability insurance is irrelevant and the problem must be faced independently thereof. In practice, however, harmonious family units almost certainly would not conduct negligence suits *inter se* were it not for insurance. Such a suit, moreover, carries a clear message to the jury that the defendant is insured. Thus, such a law suit becomes in reality a travesty on the court. It is not a genuine adversary proceeding between the adversaries of record, even though it must in form be conducted as such with all the consequent restrictions. The anomaly is further intensified by the aspect of the defense attorney's loyalty being directly contra to the interests of the defendant of record who must, nevertheless, "cooperate" to a point, in compliance with the policy contract.

However, the usual arguments against allowing these suits are essentially these three: (1) that since under the common-law the spouses are "one person, one cannot sue the other;" (2) that domestic harmony would be upset; and (3) that fraudulent and collusive actions would be encouraged. Certain respectable authorities brush off these arguments as without substance. As originally presented, the first two probably are; however, it is here submitted that spouses and other members of a cohesive household are usually an economic if not legal unit, and that domestic harmony can readily be undermined by the manner that the "adversaries" play their parts and perform or fail to perform before and during the litigation. These authorities answer the third argument by saying that opportunities for fraud and collusion are not restricted to intrafamily negligence suits and that our judicial procedures can well cope with the situation. This seems unconvincing as one reflects on the realities of the problem: while fraud or collusion may not be demonstrable, loyal family members will naturally pull together and cooperate among themselves and with their attorneys, and the defendant's relationship with the insurer and the attorney it provides will be at least cautious. Such litigation is not suited to our adversary system and our attorney-client principles.

The above discussion indicates that the states most concerned with the question are the domicile and the forum. To say instead that the lex loci should be determinative simply because the issue is "substantive" seems rather perfunctory even though this is the majority view. That state has no especial concern with the basic problem. Certainly the place of an auto accident is quite fortuitous, and the rights and immunities imposed by the family relationship should not constantly

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[3] e.g., *Poling v. Poling,* 116 W. Va. 187, 179 S.E. 604 (1935), *Kircher v. Kircher,* 288 Mich. 669, 286 N.W. 120 (1939), and *Kyle v. Kyle,* 210 Miss. 204, 297 N.W. 744 (1941).

[4] *Bodenhagen v. Farmers' Mut. Ins. Co.,* 5 Wis. 2d 306, 92 N.W. 2d 759 (1958). On rehearing, 7 Wis. 2d ——, 95 N.W. 2d 822 (1959), the same day as *Haumschild,* the court abandoned this attitude and applied the law of the domicile.

[5] *Mertz v. Mertz,* 271 N.Y. 466, 3 N.E. 2d 597 (1936). Certain "public policy" arguments were also used in this decision, but such "policy" then existing was later changed by statute. Cf. *Coster v. Coster,* 289 N.Y. 438, 46 N.E. 2d 509 (1943).

[6] In addition to a lower court Pennsylvania decision, *Pittman v. Deiter,* 10 Pa. Dist. Co. R. 2d 360 (1957), the Wisconsin court also regarded *Koplick v. C. P. Trucking Corp.,* 27 N.J. 1, 141 A. 2d 34 (1958), as following *Emery.*

change as members move throughout the states during temporary absences from home. The forum, however, is most concerned with the nature of the trial that these cases promote, and so should feel free to close its courts to this sort of business. On the other hand, there is a practical reason for not characterizing the question broadly as a procedural matter for the forum to decide: if a forum which is not the domicile allows such suits and insists on applying its non-immunity in the face of immunity in the states of accident and domicile, there obviously will be "shopping" for such a forum. Apart from the collusive flavor imbued in these suits, the real substantive question is whether or not one member of a family household has the capacity to recover money in tort against another (via insurance), and the state where the family lives, and which regulates the incidents of family relationship, does seem to have the most significant interest in this question. Thus, the *Haumschild* and *Emery* cases are sound and should be followed in principle.

Incidentally, this problem of *immunity* is quite separate from the question of the degree of fault a guest in a car must show against the host. Normally, that is determined by the lex loci: thus, a Wisconsin wife riding with her husband in a state requiring gross negligence or another form of misconduct will still have to show such behavior regardless of the law in her domicile or in the forum. The guest-host relationship, in itself, is a fairly transitory thing and lesser considerations apply. Finally, the collateral question of insurance coverage apart from liability remains distinct. The controlling law is that of the state where the policy contract was made.[1]

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[1]In New York, by statute, a policy does not cover a spouse unless expressly so provided. In *New Amsterdam Cas. Co. v. Stecker*, 3 N.Y. 2d 6, 143 N.E. 2d 357 (1957), a policy issued in New York was held not to cover a wife's injuries occurring in Connecticut. Cf. *Maryland Cas. Co. v. Jacek*, 156 F. Supp. 43 (D. N.J., 1957), holding that a New Jersey policy covered such an accident though it happened in New York.

# Total and Partial Disability – Where Do You Draw The Line?

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TODAY, Mr. Average Citizen very probably has an accident or health insurance policy containing the following phrase:

> "TOTAL DISABILITY. (A) Or, if such injuries, directly and independently of all other causes, shall, within twenty days from the date of the accident, wholly and continuously disable the Insured and prevent him from performing any and every duty pertaining to his occupation, the Company will pay weekly indemnity at the rate hereinbefore specified for the period of such continuous total disability, but not exceeding fifty-two consecutive weeks. After the payment of weekly indemnity for fifty-two weeks as aforesaid the Company will continue the payment of weekly indemnity of the same amount thereafter so long as the Insured shall be wholly and continuously disabled by such bodily injuries from engaging in any occupation or employment for wage or profit."

This may be phrased in different manners, including the words "confined to the household," or "confined to his bed;" it may be conditioned upon being under the care of a regularly attending physician; it may not allow the insured twenty days from the date of the accident until the condition is established; but fundamentally the provisions are somewhat the same. Normally they are conditioned upon loss of employment, for the typical policy is to cover the wage earner in the event of total disability.

The definition of "partial disability" within the policy will read somewhat as follows:

> "PARTIAL DISABILITY. (B) Or, if such injuries, directly and independently of all other causes, shall within twenty days from the date of accident or immediately following a period of total disability covered under Section A, continuously disable and prevent the Insured from performing one or more important daily duties pertaining to his occupation, the Company will pay for the period of such disability, but not exceeding twenty six consecutive weeks, a weekly indemnity of two-fifths of the amount payable for total disability.
>
> "No payment of weekly indemnity shall be made in case of any loss enumerated in Part 1, except as therein provided."

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Faced with an insurance policy phrased in these terms and an insured suffering from one type of disability or another, it would seem conclusive from the phrases in the policy that the insured's disability is clearly total or partial, and the question is one of degree. In fact, 7 Couch, *Cyclopedia of Insurance Law*, Section 1689, rather cursorily remarks that the question of total or partial disability is simply a question of fact.

And so did the New York courts simplify the matter in the 1946 case of *Andrews v. Travelers Insurance Company*, reported in 11 C.C.H., *Life Cases, page* 275, where the court remarked that you should read the language of the two clauses of the policy together; i.e., the insured was totally disabled if he could perform no function of his work, was partially disabled if he was prevented from performing one or more functions of his work. In this event, an insured painter and electrician who could not raise his right arm above his shoulder was not totally disabled, for the court held it was common knowledge that electricians and painters did a certain amount of work which did not necessitate their raising their hands

above their heads. However, the case of *Employers Liability Assurance Company Limited v. Farquharsen,* 182 Tenn., 642, 188 S.W. 2d 965, contains a far better and more complete discussion of the problems involved and the distinction between total and partial disability. Here the insured was a traveling salesman and traveled in approximately fourteen states, his occupation requiring to do a considerable amount of driving. The insurance policy was taken out when the insured was a pharmacist, but the policy was subsequently changed to indicate that it was to cover him as a traveling salesman. The insured was in an automobile accident and suffered a knee injury which made it impossible for him to continue to drive his automobile. The insured, at the time of the trial, was employed doing clerical work at a substantial salary decrease. The insurance company argued that the insured could travel by other means of commercial transportation, was able to handle another type of occupation, and could drive in a specially built car, but the company's testimony conceded that the insured might have some pain from traveling, even in this type of conveyance. The court discussed the problems involved in the interpretation of the policy concerning total or partial disability. It said the real question was if the insured could perform substantially all of his duties, a slightly different slant than that used in the *Andrews* case. The court held that this was a policy to cover him as a traveling salesman and that it was clearly understood between the parties that his occupation at the time was that of a traveling salesman, and should his health prevent him from continuing in that occupation he was totally disabled within the policy.

On the other hand, see *New York Life Insurance Company v. Saunders,* at 236 W.W. 2d 692, where the insured left his grocery business because of problems of his health but entered an equally lucrative automobile agency business, and he was held not to be totally disabled within the terms of the policy.

Although on the face of most policies it would seem that the New York court is correct in the simplification of the distinction between total and partial disability, much of the confusion in the cases results from various interpretations of the total disability clause of the policy. We will further discuss the distinction between occupational and non-occupational policies with reference to total disability.

A portion of this conflict appears in *Continental Casualty Company v. Ralph B. Wagner,* 8 Cir., 195 F. 2d 936, 31 A.L.R. 2d 1216. Here the insured was covered under a policy allowing total loss of business time as long as the insured continuously suffered such total loss, and partial loss of business time if said loss of business time was not total but resulted from physical inability of the insured to perform work substantially essential to the duty or duties of his occupation. From 1924 until 1946 the insured in this case was employed by the St. Louis University as a teacher of public speaking. In February of 1946 he underwent an operation for the removal of one lung, and after that time was unable to engage in the teaching of public speaking. In 1948 the insured was employed in connection with a charitable campaign and received a salary of $535.00 a month. From 1949 until 1950 he worked in connection with another campaign and received $550.00 a month. In September, 1950, the insured was totally unable to engage in any occupation. The insurance company here brought an action to recover disability payments made to the insured during the period of gainful employment. The company's argument was that as long as the insured was able to engage in an occupation for profit they were not obligated by the policy to pay indemnity to the insured for the loss of his particular employment.

As the case arose in Ohio, the court interpreted Ohio cases and held that the contract provided for monthly indemnity for the loss of all business time, payable so long as the loss was total and continuous, and a monthly indemnity for partial loss of business time, defined as the inability of the insured to perform the work substantially essential to the duties of his occupation. They said that the occupation of the insured was stated in some detail on the face of the policy and the premium for the policy was based upon the hazards incident to the insured's occupation. The court said that had the company intended the words "loss of business time" to refer to any occupation or work in which the insured was able to engage for profit or compensation, it would have said so. Since the company had failed to make this distinction, the insured's inability to continue

in the occupation of teaching allowed him total disability under the terms of the policy. The court failed to discuss that the disability of the insured could very possibly have been considered a partial loss of business time during the insured's period of inability to perform a particular type of work.

The normal clauses defining total and partial disability are found in accident policies providing either for disability or inability of the insured to engage in an occupation for wage or profit, and likewise are also construed in life policies, health policies and mutual benefit policies. Theoretically, there should be no distinction in the construction given to the terms of the policy, whether it is an accident policy or life policy. The real distinction lies, as earlier pointed out, where the policy covers the insured in a *particular* occupation as opposed to where the policy covers the insured engaged in *any* occupation. It would seem that if the policy indemnifies the insured in case the insured is totally or wholly disabled from engaging in any occupation or employment for wages or profit, a strict construction would require that the insured could carry on no occupation whatsoever. However, the general ruling in insurance laws is that the policy will be construed against the insurance company and in favor of the insured. Further, other complications have arisen where the insured has a dual occupation. For instance, the insured performs a certain amount of work which necessitates travel, performs some manual labor, or performs in a supervisory position which requires certain physical exertion. Often the insured will be physically disabled so that he is confined to his home where it is impossible for him to carry out any of the physical parts of his occupation. On the other hand, his mental ability may not be impaired and he may be in a position to act in a supervisory or decision-making capacity in his occupation. This individual presents a real problem for the courts, and the rule that close cases make bad law definitely applies in some constructions of the policy. A typical case of this is *Erreca v. Western State Life Insurance Company*, 19 Cal. 2d, 388, 121 P. 2d 689, where the insured's policy said he must be totally disabled by bodily injury or disease so that he was prevented thereby from engaging in any occupation or from performing any work whatsoever for remuneration or profit. His occupation had been that of a farmer engaged in grain and stock, and he suffered multiple fractures, a pulmonary embolism, and later ruptured varicose veins, so that at the time of the trial he was unable to walk without the use of a cane. He had been an active ranch supervisor, which involved a considerable amount of walking and riding and physical exertion. At the time of the trial he could perform no manual labor whatsoever; however, it was possible for him to negotiate leases, arrange for the financing of crops, and buy supplies and participate in the selling of grain. He could continue to perform all secretarial work connected with the farm. The court here took great pains to distinguish between the general or non-occupational disability and those policies which provide for occupational disabilities. They went on to say that according to the overwhelming authority the term "total disability" does not signify an absolute state of helplessness, but means the disability which renders the insured unable to perform substantial and material acts necessary to the prosecution of the business or occupation in the usual or customary way. The court held that the insured was unable to perform most of his duties as a farmer-operator and the business that he attended to during his disability, although not trivial or inconsequential, was the type of duty that was infrequently and intermittently performed and could not be said to constitute the substantial and material acts of the occupation of a farmer.

The theory of these more liberal cases comes from the recognized fact that it would be unreasonable to hold that a doctor, lawyer or a business executive was not totally disabled from engaging in any occupation or performing any work because he remained able to run a newsstand or work as a day laborer. We might ask ourselves, too, if the insurance company intended that someone was totally disabled only if he entered into what the medical profession would call a vegetable-like state. There is no question but that a person is totally disabled if completely bedridden, unable to attend to his own physical or mental welfare, unable to make decisions or, in fact, probably unable to even speak. It is not surprising then that most of the cases have held that a person may be totally disabled under the policy and can still carry on a certain amount of work.

Where the partial disability clause was added to many of the insurance policies, the courts in most states were faced with cases already defining total disability in terms that would actually be more applicable to the partial disability clause. Therefore, partial disability seems to mean a type of disability which is infrequent in time, rather than the obvious definition—that of being unable to perform one or more functions of employment.

In the final analysis, it can well be argued that the interpretation that most courts give to total disability is that most favorable to the insured. If total disability were used as the words would indicate, it would be rare that benefits would be paid under the policy. The average wage earner who enters into a contract of disability insurance necessarily assumes that the insurance will cover him providing he becomes unable to perform his normal occupation. In most policies he lists his occupation and assumes that should an accident happen or should sickness occur and he is unable to engage in that particular occupation, the total disability under the policy would be applicable. An attorney carrying a disability insurance policy would assume that because he was confined to bed, unable to attend court or attend to most of the normal functions of his occupation, he was disabled within the terms of the policy. An argument made that he could still advise clients from the bedside would seem untenable in legal thought.

In determining the interpretation of the insurance policy in your jurisdiction, it is wise to look first to the manner in which your courts have defined total disability. As indicated previously, there is some division of authority between a liberal and a strict construction of terms of the policy. The majority construe the terms liberally for the reasons previously set forth. It may very well be that under the liberal construction of total disability, the insured comes under the total disability provision of the policy and the partial disability portion is not applicable.

# The Loading and Unloading Clause*

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I HAVE BEEN requested to discuss with you for a few minutes this afternoon that subject which has become so complex and perplexing and troublesome to the insurance industry and productive of much litigation to the delight of the lawyers who represent insurance companies, namely and to wit, the loading and unloading clause. I shall mention a case or two in a few moments which might suggest that the name of the clause should be changed to the "free-loading" clause.

In addition to the provision of the standard automobile liability insurance policy protecting the insured from claims for damages "arising out of the ownership, maintenance or use of the automobile," the policy frequently contains a further clause expressly including the operation of "loading and unloading" as a part of its coverage. Now I have no doubt that whoever originally thought up that particular coverage clause felt that it was very simple and unambiguous and would seldom be brought into application. The author of the clause probably had in mind men and women handing parcels in and out of an automobile or perhaps an occasional delivery van or truck lifting something from the sidewalk onto the truck or lifting something from the truck onto the sidewalk.

As a matter of fact, it was apparently throught in the first place that the use of the automobile included the loading and unloading of it and that therefore the adding of the "loading and unloading" clause made for good reading in selling policies to the public but actually added nothing to the coverage.

This dreamy optimism didn't last very long, however, when the courts started interpreting and construing the meaning of the clause. In one of the early and leading cases on the subject, the Supreme Court of Utah in *Pacific Automobile Insurance Company v. Commerical Casualty Insurance Company of New York*, 161 P. 2d 423, 160 A.L.R. 1251, stated that the phrase "including loading and unloading" is a phrase of extension and that is expands the expression "the use of the truck" somewhat beyond its connotation otherwise, so as to bring within the policy some acts in which the truck did not itself play any part by dealing with a period when the truck itself is at rest but the goods are being moved onto or off the truck. As accidents occurred and claims arose under this clause, it soon became apparent that there was a basic question to be considered and answered in regard to unloading, and a basic question to be considered and answered in regard to loading.

In regard to unloading, the first question to be answered is, "What actions are considered as comprising the process of unloading within the meaning of the policy as distinguished from actions comprising a further phase of commerce, namely, the delivery of the goods?".

The first question to be answered in regard to loading is, "What actions constitute the process of loading within the meaning of the policy as distinguished from actions comprising an earlier phase of commerce preparatory to loading, such as bringing the goods near the vehicle?"

The early cases dealing with the clause in question were almost all cases involving the truck owner and his employees who were engaged directly in the operation of the truck and the loading and unloading

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thereof. Two separate doctrines began to take shape in the decisions, one was the "coming to rest" doctrine and the other was the "complete operation" doctrine. The "coming to rest" doctrine, of course, invariably involves the unloading of the vehicle and not the loading.

Perhaps the leading case and certainly one of the early ones supporting the "coming to rest" doctrine is *Stammer v. Kitzmiller,* a Wisconsin case reported at 276 N.W. 629 and decided in 1937. In that case, a driver of a brewery truck parked alongside the curb where he intended to make a delivery, opened a sidewalk hatchway, put a barrel of beer through the hatchway into the basement of a tavern and went inside the tavern to have the sales slip signed, leaving the hatchway open and unguarded. As always happens, a pedestrian came along the sidewalk and fell into the open hatchway and was injured.

The court held that the insurer of the brewery truck was not liable under the unloading clause because the goods had been taken off the vehicle and had actually come to rest and the vehicle itself was no longer connected with the process of unloading.

Another case which illustrates the "coming to rest" doctrine is *American Casualty Company v. Fisher,* 23 S.E. 2d 395, 144 A.L.R. 533. In this case, the driver of a truck delivered to the office of a customer a new adding machine. The driver took the machine into the office and placed it on a desk and then, while trying to install it, negligently caused it to fall off the desk and onto the foot of one of the customer's employees. The court held that when the driver took the adding machine into the office and placed it on the desk, he had completed the unloading operation and the operation had come to rest, and the accident which happened subsequently did not come within the purview of the unloading clause.

The second theory, which is much more liberal in favor of the injured person and against the insurance company, is the "complete operation" doctrine. As interpreted and followed by some courts, this theory, for all practical purposes, eliminates any distinction between "unloading" and "delivery" and between "loading" and "preparatory actions."

Perhaps the outstanding case in which the "complete operation" rule is applied is *State ex rel, Butte Brewing Co. v. District Court,* a Montana case, reported in 100 P. 2d 932. This happens to be another beer barrel case. A barrel of beer had been unloaded from the insured's truck onto a sidewalk and was about to be delivered into a customer's basement. An employee of the insured lifted a door from underneath the sidewalk so that the barrel could be lowered through it and just as the door was opened, the ever-present pedestrian stepped on the door and was injured. Although neither the truck nor the barrel of beer had any direct connection with the accident, the Supreme Court of Montana held that the accident came within the purview of the unloading clause on the theory that the unloading clause covered the actual delivery of the commodity to the customer and that any and all acts incidental to the unloading were covered.

Illustrating the point that "complete operation" is virtually the same as "delivery", is the early case of *Wheeler v. London Guarantee and Accident Company,* 140 Atl. 855. In that case, a steel girder had been transported on the insured's truck to a building which was being erected as a garage. The girder had been taken off the truck and carried into the building under construction and deposited on the floor but it stuck out a few feet onto the sidewalk. A boy approached on the sidewalk and attempted to get over the girder and, in doing so, was injured. The court held that since the girder had not been placed entirely in the building for which it was intended, that it was still being used in the process of unloading and that therefore the unloading clause of the insurance policy on the truck which had originally transported it to this location provided coverage.

Other cases following the "complete operation" doctrine both with regard to loading and unloading vehicles will be found in 160 A.L.R. 1259, at 1268 and following.

All of these cases, as I mentioned earlier, are cases involving the owner of the delivery vehicle and his employees. The general rules to be gleaned from the majority of the cases decided are as follows:

I. In construing the clause, the intention of the parties in the formation of the contract should be a controlling factor.

The terms "loading" and "unloading" are to be taken in their plain and ordinary sense and the insurance policy is to be construed as a whole.

II. The "loading and unloading" clause is a phrase of extension, expanding the term "the use of the automobile."

III. An accident, in order to be covered by the "loading and unloading" clause must:

(A) Have occurred during what the particular court considers as the process of loading or unloading; and

(B) Be causally connected with the act of loading or unloading the vehicle.

IV. An accident is casually connected with the process of loading or unloading within the meaning of the clause if the loading or unloading was its efficient and predominating cause.

I want to discuss briefly a few situations of the many, many that now clutter the law books wherein persons other than the truck owner or his employees ask for the protection of the "loading and unloading" clause on the theory that such persons are using the automobile within the intent and meaning of the insured's policy on the vehicle.

The standard automobile liability policy carries a so-called "omnibus clause" which defines the word "insured" substantially as follows:

> "With respect to the insurance for bodily injury liability and for property damage liability the unqualified word 'insured' includes the named insured and also includes any person while using the automobile and any person or organization legally responsible for the use thereof, provided the actual use of the automobile is by the named insured or with his permission."

Until comparatively recent years, it did not seem to occur to anyone involved to tie up this omnibus clause coverage for additional insureds with the "loading and unloading" clause.

However, some bright claims manager or adjuster or lawyer thought of this in trying to pass off the liability from his own company to the company which issued the policy on the vehicle being loaded or unloaded, and then a prairie fire of cases resulted and many conflicting decisions have emanated from various judicial tribunals as a result.

The typical example involving this situation is where truck owner "A" has his truck driven by his employee "B" to the premises of his customer or consignee "C" who has his employee "D" either unload or assist in the unloading of the truck.

In lifting a box of apples off the truck, "D" gets a bit careless and drops the box on the truck driver's foot and hurts him and "B" then sues "D" and his employer, the owner of the premises, for his personal injuries. What happens in the majority at least of the reported cases then is that "C" turns the claim over to the premises insurance company, his insurance carrier, who insures his liability for such a claim. Usually, this type of general liability policy does not cover "C's" employee, "D".

After the claim or case has been on file and has been pending for quite some months, somebody along the line remembers of reading of a case where the insurance on the truck was called into play in a similar situation, so then a tender is made on behalf of "C" and "D" to the automobile insurance company that wrote the liability policy on the truck involved and which, of course, had the omnibus clause above referred to and also had the usual "loading and unloading" provisions.

When this tender reaches the claims manager of automobile insurance company, who perhaps has not been involved in a similar case before, he laughs scornfully on the theory that "They can't do this to us" and nonchalantly turns down the tender of defense and advises "C" that he has his own insurance with the premises insurance company and "that's the baby that is responsible", if anyone is.

Then comes the declaratory judgment suit in which the premises insurance company, which, of course, is the real party in interest, employs its attorney to bring the suit in the name of "C" and "D", if "B's" case is still pending. If "B's" case is disposed of by settlement or judgment for the plaintiff, then, of course, the premises insurance company brings the suit against the automobile insurance company in its own name, claiming that "C" and "D" were covered by the policy on the truck, under the omnibus clause, and that it is now subrogated to their rights and claiming further that its premises liability policy has a provision that in respect of

a loss or claim arising out of the operation, maintenance or use of any non-owned automobile, the premises policy is excess over and above any other available insurance.

When the claims manager for the automobile insurance company gets this complaint and starts thinking the thing out a little more, he doesn't laugh so much and he calls up his lawyer and says, "I'm on my way over."

They then get together and usually they interpose about four defenses. First, they claim that "C" and "D" are not additional insureds under their policy because the truck was standing still and there never was any intention on their part to insure somebody that merely was taking a box of apples off the truck. Second, they claim that since "B" is an employee of their named insured, their automobile liability policy doesn't cover because the policy specifically excludes bodily injury claims of "any employee of the insured while engaged in the employment", the named insured is obviously an insured under the automobile policy, and since "B" is an employee of such named insured, the exclusion applies. Third, they claim that they weren't notified of the accident until ten months after it occurred and therefore if "C" and "D" are insureds under their policy, they have failed to comply with the condition respecting giving notice of accident. Fourth, they claim that if "C" and "D" are additional insureds, and if the exclusion clause above mentioned isn't applicable, and if they can't rely on the notice provision, then their policy also has an "other insurance" clause providing that they will only prorate in the event there is other valid and collectible insurance involving any given loss and, therefore, the two companies should prorate the loss on the basis of the respective limits of their policies.

These several defenses are somewhat reminded of the case where the man was sued for a pitcher which the plaintiff claimed defendant borrowed and damaged and then failed to return. The defendant answered the complaint by saying that he never borrowed the pitcher, and, if he borrowed it, he returned it, and, if he returned it in a damaged condition, it was in that same condition when he borrowed it.

Although there are a number of exceptions, most of the decided cases reject the said four defenses asserted by automobile insurance company.

The cases usually hold that "C" and "D" definitely fall within the definition of additional insureds under the omnibus clause and, since they were engaged in unloading the vehicle, that comes within the meaning of using it for loading and unloading purposes.

The second defense of the automobile insurance company, regarding the exclusionary clause involving employees of the insured, has surprisingly found considerable support in the authorities, although a majority of the decided cases hold that the exclusion as to employees only is applicable where the insured who was being sued is the employer of the plaintiff. In other words, if the injured plaintiff is suing someone who may be an insured under the policy but who is not his own employer, then the exclusion doesn't apply.

As I stated before, however, quite a few courts have sustained this particular defense and you will find the cases generally collected in 127 A.L.R. 542 and 50 A.L.R. 2d 78.

I want to commend to your consideration one case that did sustain this defense, which is one of the most enjoyable decisions I have ever read by reason of the pungent language of the judge who wrote it. I am referring to the case of *American Fidelity and Casualty Company v. St. Paul-Mercury Indemnity Company*, 248 F.2d 509.

This is a rather long decision and I am not going to intrude upon your time by setting forth the entire case, but I hope each of you will read it because I know you will get many chuckles from it. To illustrate my point, I am going to quote the first paragraph which sets the tenor for the entire decision, to-wit:

> "On facts, strikingly simple, neither complex nor conflicting, we have again the problem of an insurer who has written the policy and taken the assured's premium urging him to go elsewhere, tentatively if not finally, because another insurer is, or ought to, or may be, liable for the whole, half, or part a loaf. In the process the moving insurer generally garbs itself in the appealing robes of some assured so that, casting itself in a strange role, it asserts what it so often denied that the policy should be liberally construed and, by a bare toe

hold manages to make itself enough of a party to force a construction of another contract made by another insurer with another assured and which, under no circumstance, was made for its benefit. So it is here. Coming as it does the accident and the assureds seem all but forgotten as the two insurers match clause against clause, coverage against exclusion, claim against denial, in this battle between fortuitous adversaries."

The third defense is that if "C" and "D" are additional insureds, they have given up any rights they might have under the policy of automobile insurance company because they did not give notice within the requirements of the policy. The courts uniformly have rejected this defense on the theory that "C" and "D" did not know or realize that they had coverage under the truck policy and as soon as this was brought to their attention, they then promptly gave notice of the accident. Many courts also reject the defense on the theory that there was no prejudice from the late notice to automobile insurance company. Some courts also hold that since automobile insurance company denied coverage when the claim was referred to it, it cannot stand on the notice provision but this is a non sequitur and doesn't make much sense.

Cases illustrating the foregoing point on notice are *U.S.F.&G. v Church,* 107 F. Supp. 683, and *Scott v. Inter-Insurance Exchange,* 186 N.E. 176.

The fourth defense of a partial nature, that if there is coverage under the truck policy the claim should be prorated, is usually resolved against the automobile insurance carrier. The courts reason that since the premises policy specifically provides that it is excess over any available insurance on non-owned automobiles and since the automobile policy provides that it shall prorate with other valid and collectible insurance, the premises policy is not valid and collectible insurance, by reason of its excess clause, and that therefore the truck policy is primary and the premises policy is excess.

I have cited to you for the purpose of this discussion only the classic example of a premises employee helping to unload the truck by manually carrying merchandise therefrom. There are, of course, many, many varying situations which must be taken into account, such as where the premises employee is using tongs or a crane or a power shovel or a lift truck or other mechanical equipment in connection with the loading and unloading of the vehicle.

Perhaps the leading case illustrating the law on this type of situation is *Bituminous Casualty Corporation v. Travelers Insurance Company,* 122 F. Supp. 197.

I now want to call to your attention one or two cases, with which you might already be familiar, showing the lengths to which some of the courts have gone in applying the coverage of the automobile policy as a result of the "loading and unloading" clause.

In *Panhandle Gravel Co. v. Wilson,* 248 S.W.2d 779, one Fred Barger owned a gravel truck. He went to the quarry of Panhandle Gravel Company and had his truck loaded with gravel by that company. The loading was completed and he left the quarry and was driving down the highway and was hailed finally by an automobile who claimed that a rock had come off his truck and through the windshield of the car and injured a passenger in the car.

The injured passenger sued among others Panhandle Gravel Company and the Texas court held that said company was covered for this highway accident by the insurance policy on Mr. Barger's truck by reason of the "loading and unloading clause", since it had originally loaded the truck.

In *Lumbermen's Mutual Casualty Company v. Employers' Liability Corp.,* 252 F.2d 463, a gentleman by the name of Peloquin bought some furniture from Northridge Furniture Company and was given credit for some old furniture at his home. Northridge sent its truck with a couple of its employees to Peloquin's home to pick up the old furniture. A divan was being lowered by Northridge's employees from the second story to the ground and while they were doing this, Peloquin fell off his own front porch and hurt himself and sued Northridge and Northridge's employees claiming their negligence caused him to fall off the porch.

Northridge had two insurance policies, one on his truck and another comprehensive liability policy insuring any liability he might have for bodily injury claims arising out of the conduct of his business but excluding claims arising from the operation of motor vehicles.

As you no doubt surmise, the two insurance companies promptly got into a hassle as to which covered this particular claim and believe it or not, it was judicially determined by the United States Court of Appeals for the First Circuit that the insurance policy on the truck covered this claim, since the lowering of the divan to the ground was a process connected with the eventual loading of the truck and therefore Mr. Peloquin's fall off his own front porch was covered liability-wise by the truck policy.

It is interesting to note that during the course of the argument of this case the attorney representing the comprehensive liability policy told the court that in his opinion the truck policy would be applicable to the claim even though the truck had not yet arrived at Peloquin's residence.

Perhaps the most extreme case that has been decided against the automobile coverage is *Wagman v. American Fidelity and Casualty Company*, a New York case, reported in 109 N.E.2d 592.

In that case, Gilbert Carrier Corporation was engaged by Bond Stores to haul garments from one of its stores to its warehouse. Gilbert Carrier Corporation drove a large flatbed truck over to Bond's store and parked it in front of the store. Two of Bond's employees would bring garments out on hangers to the curb line and the truck employees would then lift the hangers onto the truck.

A department manager for Bond, by the name of Wagman, who did nothing whatever with regard to moving the garments out onto the sidewalk or putting them onto the truck, went out on the sidewalk only to count and check the clothes for inventory purposes for Bond. After doing so, he turned to go back into the store and he bumped into a pedestrian, causing her to fall to the sidewalk and become injured. She sued Wagman for her injuries and Wagman, in this decision, is given the protection of the insurance policy on the truck under the "loading and unloading" clause.

This case, as much as any other that I have read, provokes my suggestion that this clause should be called the "free-loading" clause rather than "loading and unloading."

The great amount of litigation that has arisen between insurance companies in these situations where there is a coverage question between the automobile policy and the premises or general liability policy has been costly and wasteful and time-consuming. In an effort to eliminate this type of litigation, an important committee, representing a large proportion of the insurance industry, has published some guiding principles to which member companies have subscribed. The committee I refer to is the Combined Claims Committee of the Association of Casualty and Surety Companies and the National Association of Mutual Casualty Companies.

This committee has recommended two classical examples of claims arising in this general field and the solution that should be agreed upon and arrived at without litigation.

*Example*: The truck of "B" is being loaded at the premises of "A". Employees of "A" drop a pipe that is being loaded onto the driver of "B". "B" sues "A".

*Solution*: The auto carrier of "B" should cover. If held liable, "A" would have an action against its negligent employees and since the liability policy of "A" normally would not cover "A's" employees, the ultimate obligation would fall on "B" in most cases anyway.

*Second Example*: The truck of "B" is being loaded at the premises of "A" by the use of "A's" crane. The cable of "A's" crane breaks, dropping the load on "B's" driver who sues "A".

*Solution*: Liability carrier of "A" (premises policy) should cover. When accident occurs by reason of defective equipment of one insured used in loading or unloading the vehicle of another insured, the carrier of the insured owning the defective equipment should cover.

These are sensible recommondations and if the insurance industry would follow them and try to work other situations that can arise within the intent and meaning of these two examples, a great deal of costly and unnecessary litigation would be eliminated.

The recommendations just referred to and a very informative and interesting discussion of them and, of course, the usual exceptions, will be found in an article in the Insurance Counsel Journal, Volume XXVI, page 93 (January, 1959) by Allan P. Gowan, General Claims Attorney for the Glens Falls Insurance Company and a Regional Editor of this particular publication.

# OF LAW AND MEDICINE

*Medicolegal subjects, the doctor-lawyer relationship, medical evidence, expert medical testimony, medical malpractice and its trends, and similar topics, will be presented in this department. The Journal will be pleased to have its readers submit articles of this type, either written by them or which may come to their attention.*

## Captain Of The Ship

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FOR MANY YEARS, doctors and lawyers who handle damage suits have heard the expression "Captain of the Ship" applied to surgeons in the operating room. Perhaps in the earlier days when there were no public hospitals such as we know today, there may have been some reason or enough similarity in the positions of the surgeon and a captain to warrant favorable comparisons in certain instances. But in the practice of medicine, particularly in the hospital operating room today, there is no comparison and the doctor has been shorn of the captain's bars and his "cat of nine tails". When the phrase became popular, the "captain of the ship" was responsible for the voyage and all of the men on the ship. He was all power. He had the power to hire, to fire, to designate work, and it has even been rumored that some of the crew was shanghaied. By way of punishment, in addition to firing, he could put the offender on a low-ration diet, confine him to the brig, or, in an extreme case, punish him by death. The doctor has never had such authority.

In the present-day operating room, there will be three to six people present other than the doctor. The doctor does not have the power to hire or fire any of those persons. He does not select the personnel. He does not pay them. He does not train them. In fact, he has no control over the personnel which is assigned to the operating room by the hospital. Those in attendance are trained in the manner and method prescribed by the hospital. They are assigned to the operating room by the hospital. They may even disobey the doctor during the course of the operation without too much fear of the doctor. Cases have been reported where hospital employees have refused to follow the instructions or advice of the physician in the operating room. The doctor may report the employee and refuse the services of such an employee in future operations, but the hospital has the final say as to whether or not the employee was justified in refus-

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ing to obey the physician's instructions. He cannot dictate to the hospital as to the type of training or the amount of training any technician should receive before being assigned to the operating room.

It is now solely within the prerogative of the hospital to extend or withhold the privilege of using the hospital's facilities to any physician making application to practice in such hospital. When his position under these circumstances is compared to the "captain of the ship" one can readily see that even if that catchphrase had any application to the doctor's rights and liability in the operating room in the early days, it certainly has no application today.

We all recognize that someone must be responsible for the well-being of a patient who is under sedation and helpless in the operating room. Why should the doctor automatically be the goat?

The hospital facilities are contracted for independently by the patient. The doctor can go no further than suggest a certain hospital. In the operating room there are usually three to six people and everyone who participates has had prior technical training to do a specific job under given circumstances. Many necessary movements are made and many things are accomplished toward the operation and the well-being of the patient without an order being given.

The trained technicians know what they are supposed to do under a given circumstance, and they go about the job in a business-like manner in the way they have been trained. Any operation in the operating room is a serious one. The doctor is intent upon accomplishing the desired results. To hold him responsible for (example) eight hands and four bodies of other people in the operating room would be requiring the impossible. He could not watch every movement made by the four people assisting. If his mind is on each movement they make, and he watches the sponges, the instruments, the anesthetist, the gauges for the anesthetic, the position of the people, the placement of hotwater bottles, temperature of the water, the strapping of the patient to the table, and things of that nature, there would be very little time to attend to the prime object, the operation. It cannot be denied that when a patient is put on the operating table it is desirable, and sometimes necessary, to complete the operation in a hurry with the least assault upon the body of the patient. During the operation, the doctor has to watch the pulse, the heartbeat, the blood pressure, ligaments, blood vessels, muscles, and many other things that are necessary. His personal attention is required to insure good results. To hold him responsible for every action in the operating room, when it is known that he cannot actually watch the actions of other people for which the hospital charges, would be charging him with superhuman responsibility. The hospital sets its price and determines the caliber of assistants, all based upon their agreement with the patient. The doctor has no part of this agreement. We recognize that there are a great many cases in which the hospital and the physician may both be liable. There are other cases in which the doctor solely should be liable, and again there are cases where only the hospital should be liable.

Let us consider some examples: In a tracheotomy procedure, where the doctor is administering the anesthetic himself and the nurse is holding the patient in an upright position on the operating table, should the doctor be responsible when he is preparing to administer the anesthetic and does not have his eyes riveted on the patient, if the nurse walks off and leaves the patient to fall from the operating table?

During the course of a serious operation where the patient's life may be at stake and it is necessary to apply hotwater bottles to the body of the patient, should the doctor cease in the middle of a serious heart or brain operation or any other serious operation to test the temperature of the water before allowing the hospital employee to put the bottle against the body of the patient? If he is the "captain of the ship" he would be responsible if the water is too hot and the patient suffers a burn even though the operation may be successful. On the other hand, I am sure any jury would hold the doctor liable if the doctor abandoned the operation to test the temperature of the water and the patient died because of prolonged exposure or unskillful delay during the time the doctor is testing the water temperature.

Suppose the doctor is busy suturing an artery and one of the attendants drops a sharp instrument on the patient, or the attendant goes berserk and deliberately cuts the patient: should the doctor be liable because he is in the operating room?

Suppose an orderly is transferring a patient from the cart to the table before the procedure begins and the patient falls to the floor. The doctor is in the operating room scrubbing or arranging his instruments. Should the doctor be held liable for letting the patient fall?

These examples illustrate the ridiculous "captain of the ship" idea. The hospital is in business. It not only hires nurses, furnishes food, beds and orderlies, it actually employs doctors who render treatment in the absence of the attending physicians, sometimes with and sometimes without specific instructions from the doctor depending on the urgency of the situation.

It is time the relationship between the hospital and the doctor be re-examined and the responsibilities divided where they can clearly be divided. The physicians themselves are not entirely blameless for the antiquated thoughts that have been brought into modern times. They have been drilled into the doctors at medical colleges. The chances are that if you ask an old-time physician about the responsibility of a doctor in the operating room he will say that the doctor is liable for everything that transpires in the operating room. Some of the more modern authorities have taken cognizance of the changes in conditions, but the supportive authorities for these changes are understandably slow when the doctors and the courts are dragging their feet.

In Florida, as in some other states, the res ipsa loquitur doctrine is not applicable in malpractice cases. However, there has been a general trend throughout the country in recent years to relax the rules requiring proof that the doctor has failed to use that degree of care commonly exercised by like qualified and trained physicians in the community. A Florida case somewhat in point is *Wilson v. Lee Memorial Hospital,* Fla, 1953, 65 So. 2d 40. In that case, a sponge had been inadvertently sewed up in plaintiff's abdomen following an operation, and plaintiff sued the hospital and the doctors involved. The lower court granted a summary judgment in favor of defendant hospital, and plaintiff appealed. The supreme court reversed this summary judgment finding that an issue of fact was raised by the pleadings and affidavits as to whether the nurse and surgeons were agents of the hospital. In addition, the court stated:

"These cases approve the rule that when one employs a surgeon, enters a hospital, public or charitable, and receives treatment of a nurse furnished by the hospital, but who is under the direct supervision of the surgeon, that said nurse is the agent of the doctor and the hospital is not liable for her negligence while acting under the *direction* of the doctor. *Neither* is the hospital responsible for the *doctor's* negligence. These cases also approve the rule that under the doctrine of respondeat superior a hospital, private or charitable, is liable to a patient for the torts of its employees. Such is the rule in this state. City of Miami v. Oates, 152 Fla. 21, 10 So. 2d 721; Pensacola Sanitarium v. Wilkins, 68 Fla. 447, 67 So. 2d 124; Parrish v. Clark, 107 Fla. 598, 145 So. 848.

* * * * *

"The pleadings squarely present the question of whether or not the nurse was agent of the hospital or the surgeons or whose agent the nurse and the surgeons were. If the nurse or the surgeons were agents of the hospital, under the doctrine of respondeat superior it was error to dismiss it as a party. At any rate, the pleadings raise an issue that should have gone to the jury." (Emphasis supplied)

This Wilson case was referred to in a recently published text, *Law of the Hospital and Nurse,* Hayt, Groeschel & McMullen, copyright 1958. In Chapter 12, dealing with operating room responsibility, the writers, on pages 157 and 158, state:

"While a nurse is a general employee of the hospital, for particular purposes she may become a special employee of the surgeon. The use of the word special in this sense related to an individual designated *to perform a specific* function. Her negligence becomes imputable to the operating surgeon on *showing that he had complete control and supervision* over her acts during the operation.

"In legal phraseology, the term imputed means attributed vicariously; that is, an act, fact or quality is said to be imputed to a person when it is ascribed or charged to him, not because he is personally cognizant of it or responsible for the particular act, *but because he*

*has control over another person for whose acts or knowledge he is responsible.*

"A person is considered an employer when he has the right to control and direct the individual who performs the services not only as to the result to be accomplished but also as to the means to be used. The individual subject to direction is the employee.

*"When one person receives treatment by a nurse furnished by the hospital, but who is under the direct supervision of the surgeon, the nurse acts as the agent of the doctor. The Hospital is not liable for her negligence while she serves under his direction. Neither is the hospital responsible for the doctor's negligence."* (Emphasis supplied)

The writers go on to consider other stronger cases, which will be considered below, finding that the surgeon is responsible for the nurse's negligent acts during the operation when the surgeon has supervision and control over her.

The above-noted text also deals with the responsibility for injections of medication. On page 196, the writers state:

"The injection of medications by a nurse is a *medical act* which must be ordered by a physician. Selection of the drug and need therefor is for his determination; the nurse acts *as his agent;* it is not her obligation to administer any further medications unless ordered by him...

"The failure of the nurse to administer the drug properly may subject her to personal liability and may impose liability on the hospital employing her. A number of recent cases set forth the reaction of courts to errors in the injection of medications by nurses...

"In cases involving injections by nurses, the courts appear to be concerned primarily with whether or not the nurse performed the act with due care." (Emphasis supplied)

The cases cited in the above section do not specifically deal with instances where injections are given in the operating room or where the doctor has supervision and control. *Bryant v. Presbyterian Hospital in City of New York,* N. Y. 1953, 110 N.E. 2d 391, involved a case where a nurse gave plaintiff an injection in the buttock while in the ward, and this injection was allegedly improperly performed and injured the sciatic nerve. A directed verdict in favor of the hospital was affirmed on the ground that identity of the nurse and lack of care was not shown. Another case which is factually similar, *Bauer v. Otis,* Calif. 1955, 284, P. 2d 133, was based on a claim that a nurse had improperly injected the deltoid muscle, causing "wrist drop", and negligence of both the doctor and nurse was alleged. Judgment for defendants was reversed on the ground that the lower court had refused res ipsa loquitor instructions, however this case did not involve an operation or suit against a hospital.

Corpus Juris Secondum, Vol. 70, Physicians and Surgeons, Sec. 54f, provides:

"A physician is not liable for the negligence of hospital or other nurses, attendants, or internes, who are not his employees, if he has no knowledge thereof, or has no connection therewith, or if it is not discoverable by him in the exercise of ordinary care, or unless he is negligent in permitting them to attend the patient, or unless the negligent acts were performed under conditions where, in the exercise of ordinary care, he could have or should have been able to prevent their injurious effects and did not. The mere fact that a physician or surgeon gives instructions to a hospital employee does not render the physician or surgeon liable for negligence of the hospital employee in carrying out the instructions.

"An employee of a hospital may be temporarily detached in whole or in part from the hospital's general control so as to become the temporary servant of the physician he assists, in which case the surgeon will be subject to liability for the employee's negligence Where a hospital nurse although not in the regular employ of an operating surgeon, is under his special supervision and control during the operation, the relationship of master and servant exists, and the surgeon is liable, under the doctrine of respondeat superior, for the nurse's negligence."

Also see 41 C.J.S. Hospitals, Sect. 8 C. (2)

American Jurisprudence, Vol. 41, Physicians and Surgeons, Sec. 112, states in part:

"It is the established rule that a physician or surgeon must exercise due care

in selecting his assistants, and on the simplest principles of the law, agency, or of master and servant, a physician or surgeon may be liable for the neglect or fault of his employee or servant, such as an assistant who is working under his direction, for injury resulting therefrom to a patient. *The courts are divided as to the liability of an operating surgeon for the negligence of nurse assisting him in the operation.* Generally, he is held liable where the relation of master and servant exists between them or where the facts call into operation the doctrine of respondeat superior, even though the assisting nurse may not be in the regular employment of the operating surgeon, although a surgeon may be liable independent of the doctrine of respondeat superior, as where the surgeon delegates to a nurse the performance of duties which are properly his as part of the operation, such as accounting for instruments, sponges, etc., used in the operation. Other jurisdictions, however, adhere to the contrary rule and absolve the surgeon from liability for negligence of a nurse to whom he has delegated such duties as accounting for sponges used in the operation. The application of the doctrine of respondeat superior to such cases has been approved by one court because of the helplessness of an anesthetized patient and the complexity of surgery under modern hospital conditions. In the absence of any relation of agency, an operating surgeon is not liable for the negligence of other physicians, internes, or nurses left in charge of a patient to administer to him the care and service which is necessary after completion of the operation, although there is authority to the contrary." (Emphasis supplied)

American Jurisprudence, Vol. 26, Hospitals and Asylums, Sec. 15, provides in part:

"A hospital conducted for private gain is liable to its patient for injuries sustained by him in consequence of the incompetency or negligence of a physician treating him at its instance, under a contract binding it to furnish him proper treatment. A physician so employed is not an independent contractor. But if the negligence is in fact that of an independent physician or surgeon, the hospital in which the treatment occurs will not be liable."

Numerous cases are cited in the above authorities, and also in 60 A.L.R. 147, an annotation dealing with the "Liability of Operating Surgeon for Negligence or Lack of Skill or Nurse Assisting Him," printed in 1929. The A.L.R. Blue Book of Supplemental Decisions indicates cases in point up to the present. Other sources reviewed were the Sixth Dicennial Digest, under Physicians and Surgeons, Section 16, and under Hospitals, Section 7. Rather than review all the cases found, we shall attempt to select the leading cases, and then list other cases to indicate the holdings in various jurisdictions.

*Aderhold v. Bishop,* (Okla. 1923) 221 Pac. 752, is the case upon which the abovementioned annotation, 60 A.L.R. 147, is based. In that case, claimant was burned during an operation because of the negligence of hospital nurses in placing a pan of hot water too close to plaintiff's feet. The court held that operating surgeons were not personally negligent; however, the negligence of the general employees of the hospital was imputable to them. The court affirmed the judgment for the plaintiff after providing for a remittitur, and stated:

"....While the head nurse and her assistants were the general employees of the El Reno Sanitarium, they were nevertheless, during the time required for the actual operation, under the direction and supervision of the operating surgeons, and were the servants of the operating surgeons in respect to such services as were rendered by them in the performance of the operation, and for any negligence on the part of such employees in the performance of such services the operating surgeons are liable."

Referring to prior authorities, the court quoted the following:

"Where a servant has two masters, a general and a special one, the latter, if having the power of direction and control, is the one responsible for the servant's negligence...."

"The power of control is the test of liability, under the maxim respondeat superior. If the master cannot command the alleged servant, then the acts of the

latter are not his, and he is not responsible for them. If the principal cannot control and direct the alleged agent, then he is not his agent...."

"The maxim of respondeat superior is founded on the principle that he who expects to derive advantage from an act which is done by another for him must answer for any injury which a third person may sustain from it."

It must also be noted that, in the above case, the hospital was owned and operated exclusively by the defendant operating physicians. They were officers and shareholders in the corporate hospital.

In *McConnell v. Williams,* (Penn. 1949) 85 A. 2d 243, the appellate court reversed a non-suit and held that the operating surgeon may be liable for the negligence of an intern in the operating room in placing an overdose of chemical in a baby's eyes. At the time of the negligent act, the surgeon was treating the mother following a Caesarian operation. The surgeon delivered the baby to the intern for the purpose of tying the cord and applying the solution to the baby's eyes. There was testimony to the effect that the surgeon had complete control of the operating room and that such "supreme control" is essential in view of the high degree of protection to which an unconscious patient is entitled. It was also noted that the hospital furnished the services of the intern, furnished the chemical solution and the facilities of its laboratory. The court referred to the rule that "responsibility is commensurate with authority" and the Restatement of Agency, Sec. 227, and also stated:

"....The difference between the hospital supplying mere mechanical implements or medicines, and its furnishing at defendant's request, an intern to assist him in the operating room in the discharge of a duty which rested primarily on defendant's shoulders, is obvious, because, by the intern's becoming subject to his control, he becomes responsible for the proper performance by the intern of all acts done in subordination to such control, whether defendant actually exercised it or not, and it would make no difference, in view of such control, whether the intern was furnished by the hospital or had been obtained in some other manner."

It should be noted in this case that the intern was actually selected by the defendant surgeon. There was also a lengthy dissent by Justice Stearne, arguing that the defendant should not be responsible because he was the senior staff surgeon of the charitable hospital and his services would be included in plaintiff's contract with the hospital for services. He concluded that the majority opinion made the surgeon personally responsible for service rendered by the hospital.

In a more recent Pennsylvania case, *Benedict v. Bondi,* (1956), 122 A. 2d 209, the appellate court reversed a non-suit in favor of defendant surgeons and nurses. The non-suit in favor of defendant hospital was affirmed. In this case a hospital nurse had negligently burned plaintiff's feet with hot water bottles during an operation. The surgeon told the nurse to apply the hot water bottles, and assumed this would be done in the proper safe manner. The court, referring to the *McConnell* case and other cases setting forth the respondeat superior doctrine, stated that whatever goes on in the operating room insofar as the operation is concerned is the surgeon's responsibility. The nurses administrative acts in preparing the operating room were distinguished. Here the nurse's improper application of the bottles during the operation was a medical or therapeutic act (see Hayt, Hayt & Groeschel, *"Law of Hospital, Physician and Patient,"* 2nd Ed., p. 305). This is not a routine matter to be performed in all operations, and it was a procedure to be ordered by the operating surgeon.

*Ybarra v. Spangard,* (Cal. 1944), 154 P.2d 687, 162 A.L.R. 1258, concerned the application of the doctrine of res ipsa loquitor where the patient was improperly strapped to the operating table and sustained a shoulder injury. The appellate court reversed the non-suit entered by the lower court, and inter alia, held that the doctor in charge of the operation could be liable for the negligence of those who become his temporary servants for the purpose of assisting in the operation. He was thus responsible for the neglegent acts of assisting physicians and nurses who were employed by the hospital.

In *Covington v. Wyatt,* (N. C. 1928), 145 S.E. 673, a non-suit in favor of the defendant surgeon was affirmed. The surgeon had delivered the baby and then requested the hospital nurse to obtain the

proper silver nitrate solution. The surgeon held the baby's eyes open while the nurse applied the solution to the baby's eyes. A thirty per cent (30%) solution was used instead of the proper one per cent (1%) solution and the baby's eyes were burned. The respondeat superior doctrine was not considered by the court, which concluded that negligence or malpractice by the doctor had not been shown. The court also stated that the nurse was employed in the usual course of her business in the hospital, that she had not been selected by the defendant surgeon, that the chemical solution was kept in another room in the hospital medicine cabinet which was under the hospital's control, and that it was customary for the solution to be instilled by the hospital nurse.

However, the same jurisdiction in a later case, *Jackson v. Joyner,* (N.C. 1952), 72 S.E. 2d 589, held that an operating surgeon could be liable under respondeat superior for the negligence of a hospital nurse. Jury verdict for defendant surgeon was reversed because of improper instructions. Here the hospital nurse had improperly administered the anesthetic causing the patient's death. The court stated that the surgeon had full power of control over the nurses in the operating room, and that he would be responsible for the manner in which the anesthetic was administered by the nurse. The court also referred to the lent servant doctrine which applied during the duration of the operation. Where a servant has two masters, a general and a special one, the latter, if having the power of immediate direction and control, is the one responsible for the servant's negligence. 35 Am. Jur., Master & Servant, Sec. 541, 539.

*St. Paul-Mercury Indemnity Co. v. St. Joseph's Hospital,* (Minn. 1942) 4 N.W. 2d 637, has been frequently cited in later cases. This involved alleged negligence on the part of the operating surgeon and hospital nurses in obtaining and using water which was too hot in washing the patient's wound. The surgeon settled his phase of the case and suit was then brought against the hospital. Judgment in favor of defendant hospital was affirmed. The court stated that a hospital is liable for the torts of its employees under respondeat superior, however, the hospital is not responsible when the nurse is the lent employee of the surgeon during the operation. The element of control was determinative, despite the face that the nurses were in the general employ and pay of the hospital and were assigned by the hospital to assist in the operation. The court further stated:

> "The desirability of the rule is obvious. The patient is completely at the mercy of the surgeon and relies upon him to see that all acts relative to the operation are performed in a careful manner. It is the surgeon's duty to guard against any and all avoidable acts that may result in injury to his patient."
>
> "....In the operating room the surgeon must be master. He cannot tolerate any other voice in the control of his assistants."

This holding was reiterated by dicta in a more recent Minnesota case, *Swigerd v. City of Ortonville,* (1956) 75 N.W. 2d 217. Pre-operative or post-operative treatment by hospital nurses and administrative acts also distinguished. In this regard, it may be noted that Louisiana has held that the operating surgeon is even responsible for "after-treatment" when he is not present and not in control of the hospital employee. *Messina v. Societe Francaise de Bienfaissance et D'assistance Metuelle de la Nouvelle Orleans* (La. 1936) 170 So. 801. This case involved an injection by an intern of medication which was too hot. It appears that Louisiana is in the definite minority in extending the surgeon's responsibility to "after-treatment."

Other jurisdictions also holding the operating surgeon liable for the negligence of hospital employees during an operation are indicated by the following cases: *Minogue v. Rutland Hospital,* (Vt. 1956) 125 A. 2d 796; *Beadles v. Metayla,* (Colo. 1957), 311 P. 2d 711; *Johnson v. Ely,* (Tenn. 1947) 205 S.W.2d 759. Other cases in point include *Jordan v. Touro Infirmary,* (La. 1922), 123 So. 723; *Bird v. Marion General Hospital,* (N. C. 1932) 162 S.E. 738; *Ales v. Ryan,* (Cal. 1936) 64 P. 2d 409; and *Randolph v. Oklahoma City General Hospital,* (Okla. 1937) 71 P. 2d 607. *Brown v. Moore,* U.S. District Court, W. D. of Penn. 1956, 143 F. Supp. 816.

Cases holding that the operating physician is not responsible for the negligence of a hospital nurse assisting him will now be reviewed. It might first be noted that the annotation in 60 A.L.R. 147, referred to above stated that all the cases reviewed, with the exception of the *Aderhold* case,

assumed that the relation of master and servant did *not* exist between the surgeon and the nurse. The relevant cases will now be considered, but it should be noted that the clear majority of subsequent cases cited in A.L.R. "Blue Books" find that the relation of master and servant between surgeon and nurse does exist in the operating room.

The leading case opposing surgeon's liability is *Hohenthal v. Smith,* U.S. Court of Appeals for District of Columbia, 1940, 114 F. 2d 494. The operating surgeon was sued for malpractice and judgment in favor of defendant surgeon was affirmed by the appellate court. Here the negligent act was performed by a hospital intern *after* the operation. The surgeon had instructed the intern to administer a hypodermoclysis injection, and when the injection was administered in the patient's room, the needle broke. Apparently the defendant surgeon was not present at this time. The court stated that the mere fact that the surgeon gives the instructions, or even specially designates the particular employee who is to carry out the instructions, does not give rise to a master-servant relationship. The court, however, was referring to "after-treatment", and specifically excluded acts performed during an operation. The court also stated that the fact that the defendant's instructions related to a "medical measure", an injection, did not create an employment relation so as to hold the surgeon responsible under respondeat superior. This treatment was performed on behalf of the hospital and was part of the normal duties of interns. In footnote 5, the court, still dealing with "after-treatment", stated that the significant question is whether the services are of a type normally performed by the hospital through its servants, whether nurses or interns.

In *Shull v. Schwartz,* (Penn. 1950), 73 A. 2d 402, judgment for defendant surgeon was affirmed where the hospital intern negligently removed stitches after the operation. The court observed that the stitches were not removed in the presence of the defendant or under his supervision. In addition, see *Malkowski v. Graham,* (Wis. 1919), 172 N.W. 785, which involved "after-treatment" and also *Flower Hospital v. Hart,* (Okla. 1936), 62 P.2d 1248.

*Clary v. Christiansen,* (Ohio, 1948), 83 N.E.2d 644, affirmed a directed verdict in favor of defendant surgeon. The surgeon had instructed the hospital attendants to prepare the operating room and supply a Davis Borie machine. Through negligence of one of the hospital nurses the wrong machine was substituted before the operation started, and this nurse knew of the substitution. As a result of the improper machine being used the patient was burned during the operation. It was contended that the nurse's knowlege was attributable to the surgeon as a matter of law. The court stated that the surgeon had no right to direct as to the mode or manner of preparing the room for operation. Therefore, the court concluded that the nurse was in no sense an employee of the surgeon in the task of preparing the room preceding the actual beginning of the operation and that whatever negligence occurred in that connection could not be attributed to the surgeon. *Blackman v. Zeligs,* (Ohio, 1951), 103 N.E. 2d 13, also involved negligence of hospital attendants prior to the actual operation. In that case, plaintiff was burned by certain chemicals, and a directed verdict in favor of defendant surgeon was affirmed since negligence of the hospital attendants could not be attributed to defendant.

In *Salgo v. Stanford University Trustees,* (Calif. 1957), 317 P. 2d 170, the court reversed a judgment against the defendant surgeon. In that case it was alleged that one of the surgeon's assistants, an anaesthesiologist, negligently performed an aortography causing permanent injuries through the use of a long needle. The procedure was preliminary to the actual operation. It was noted that the defendant surgeon was there at the beginning of the procedure but that he gave no instructions. The defendant neither participated in or had a right to direct this procedure. The court distinguished this factual situation from those cases which indicate that a surgeon is liable for the negligence of hospital employees under his direct supervision and control during an operation. Another California case, *Hallihan v. Prindle,* (Calif. 1936), 62 P.2d 1075, held the defendant operating surgeon was not liable for the nurse's negligent preparation of the hospital room in placing the wrong medications on the surgeon's tray. The surgeon, when the operation commenced, proceeded to inject this harmful fluid into the patient's body. The court found that the acts of preparation performed by the nurse were not under the

special supervision and control of the defendant surgeon. Although the hospital was also held not liable because it was a charitable institution, the court stated that the nurse was trained by the hospital and the hospital received the benefits accruing from their work, and further that the hospital was the employer at the time of the negligent act.*

There are several early cases indicating that the surgeon is not responsible for the hospital's nurses accounting errors, whereby a sponge is left in claimant's abdomen after an operation.

*Hall v. Grosvenor,* (Ill. 1932), 267 Ill. 119, so ruled and stated that an operating surgeon is not responsible for the mistake of a hospital nurse not his employee, where an operation is performed at a hospital not owned or controlled by the surgeon. The court stated that the surgeon must think quickly and must be relieved of the responsibility of counting sponges so as to be able to concentrate on the operative technique, and that this is necessary for it would jeopardize the life of the patient for the surgeon to attempt to keep count of the sponges used. The earlier case of *Olander v. Johnson,* (1930), 258 Ill. App. 89, was relied on. The same ruling was set forth in *Niebel v. Winslow,* (N.J. 1915), 95 Atl. 995, *Guel v. Tenney,* (Mass. 1928), 159 N.E. 451, and *Funk v. Bonham,* (Ind. 1926), 151 N.E. 22.

In *Blackburn v. Baker,* (N.Y. 1929), 237 N.Y.S. 611, the court reversed a judgment for plaintiff, where the defendant operating physician was charged with having negligently permitted a sponge to be left in plaintiff's abdomen during surgery. The court also stated that defendant was not chargeable with negligence, if any, of the nurses employed by the hospital. The case relied on for the latter holding was *Baker v. Wentworth,* (Mass. 1892), 29 N.E. 589, which involved "after-treatment" following the surgical procedure, and the court held that the surgeon was not responsible for this "after-treatment" since the hospital employees had control.

Another case, *Akridge v. Noble,* (Ga. 1902), 41 S.E. 78, affirmed a judgment for defendant surgeon where a sponge had been left in patient's abdominal cavity during an operation. The court also stated that an operation begins when the opening is made in the body and ends when the opening has been closed in a proper way. The court held that failure to use reasonable care had not been shown, and respondeat superior was not considered.

In *Steinert v. Brunswick Home,* (N.Y. 1940), 20 N.Y.S. 459, the appellate court affirmed a judgment in favor of defendant hospital. In this case, the hospital nurse negligently prepared a caustic solution to be injected into the plaintiff as an anaesthetic. The preparation was requested by plaintiff's doctor who apparently administered the injection. The court held that the negligent act by the nurse was part of the "treatment of the patient" and was not an "administrative act" and therefore the hospital was not responsible. The case did not consider the doctor's responsibility.

It should also be noted that the New York Court of Appeals in *Bryant v. Presbyterian Hospital in City of New York, supra,* held that medication given to a patient by hypodermic injection is a medical act, not administrative routine. The dissenting opinion in that case also stated that the giving of medication by the insertion of a needle into the human body is a strictly medical act.

However, note that the "medical-administrative" distinction has been abandoned in New York, as indicated in *Bing v. Thunig,* (1957), 2 N.Y.S. 2d 656, 143 N.E. 2d 3. The court announced that henceforth, the normal operation of the respondeat superior doctrine would be applied to hospitals and that hospital immunity no longer existed. In that case the hospital nurses had negligently failed to remove certain contaminated sheets from the operating table prior to the commencement of the operation. Judgment was rendered in the lower court against both the surgeon and the hospital, but judgment against the hospital was later reversed. The Court of Appeals finally ruled that the hospital was responsible under respondeat superior for the negligence of the nurses. The court stated that the test should be whether the person who committed the negligent injury-producing act was one of the defendant's employees and if so, was the employee acting within the course of his employment. It was also noted that an independent act or omission of hospital nurses was involved, and their conduct was not pursuant to orders or directions of the visiting surgeon.

The recent case of *Dohr v. Smith,* (Fla.

* (NOTE: It appears that the California law regarding charitable institutions has been changed by decision since the foregoing case.)

1958), 104 So. 2d 29, referred to the head surgeon as the "captain of the ship". However, the court held that the surgeon's responsibilities are not inextricably bound with those of the anaesthetist, although both have a common goal. The anaesthetist was charged with negligence for permitting injury to the patient during the operation, and the responsibilities of the head surgeon and hospital were also considered under respondeat superior. A directed verdict in favor of the surgeon and hospital was affirmed, but directed verdict in favor of the anaesthetist was reversed. The anaesthetist, like the surgeon, was not an employee of the hospital.

It would seem that Florida has abandoned the "captain of the ship" theory and has adopted a more just and proper legal view recognizing the responsibilities in the operating room for some action may rest upon persons other than the doctor who is in charge of the operation as is indicated by the following quotation from the above-cited case:

> "We have already referred to his attitude as the appellants describe it, but what has been written must be tempered by testimony emphasized in his brief. The surgeon may have been generally in command from the beginning of the operation to the end, or, as appellants term him in the brief, *'captain of the ship'* but it is clear to us that he and the anesthetist were working in highly expert fields peculiar to each and that despite the common goal, the successful repair of the patient's ulcer, their responsibilities were not inextricably bound together. *Hudson v. Weiland,* 150 Fla. 523, 8 So. 2d 37."

We also call attention to an interesting article appearing in 22 Insurance Counsel Journal 76, by two Florida attorneys, Harry T. Gray and Francis T. Conroy of Jacksonville, bearing upon this subject. The article is entitled "Responsibility of Surgeon for Mistakes of Others."

In view of the holdings of the various courts and our observations in the beginning of this article, we feel that a concentrated effort should be made to educate the courts, the bar, medical schools and the doctors' societies to recognize the obligations of distinct entities.

Where a person seeks to hold the doctor liable for the actions of some other person, it should be proven that the person performing the act negligently was under the control and direction of the doctor following his orders, in contrast to other cases where the doctor has been held liable merely because he is physically present in a room when some person over whom he has no direct control does a negligent act that results in injury to the complaining party. We have not meant by our observations in this article to infer that an injured party should not have a right of action where he has been injured through the neglect of another person. We do say, clearly and firmly, that there are cases in which the doctors are being sued where they should not be sued, where the recovery, if any, should be against the hospital only. Of course, we admit that there are cases where the hospital should not be sued because the injury complained of is solely the responsibility of the doctor. There is a third class of cases in which the hospital *and* the doctor should be responsible to the injured person. Sometimes it is difficult to draw a line in a given case, but these three classes of cases should be borne in mind and liability should fall on the one responsible for any negligent act.

Even in admiralty, under certain conditions, the master would not be liable to a passenger or a third party for injuries inflicted upon such a person by crew members, even though he is still the captain and has a ship to command. If the doctor ever was the captain, he is no longer "captain of the ship", and frequently he is the "goat".

# Alcoholism and Accountability*

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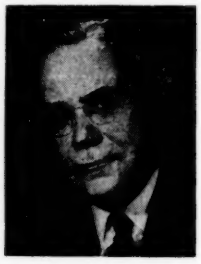
FROM TIME immemorial the excessive indulgence in the use of alcohol as a beverage has been one of the most disturbing of the many influences which affect the well being of mankind. This is probably as true in the many native cultures as in the consecutive civilizations which have appeared in the past. The basic reasons for this are manifold as modern investigations into the causes of alcoholism have revealed. The problem itself is essentially a paradox, for the initial use of alcohol as a source of pleasurable reaction not infrequently results in untoward, if not tragic, effects insofar as the drinker and those coming into contact with him are concerned. Yet the innumerable object lessons of these ill effects are slow to influence either the drinker or those who are in a position to alter his environment.

The reasons for this situation are about as numerous as those which cause the individual to indulge in alcohol in the first place. As far as the public at large is concerned, one prime cause of indifference to the total effects of alcohol is economic—the hope of increased revenues in taxes, the desire for added income from advertisements on the part of papers and magazines, or the fear of offending certain members of society on the part of jurists who are sometimes inclined to overlook the ill results of drunkenness. From the viewpoint of the individual, there are two factors which account for chronic alcoholism, other than the case of recurrent episodes of excessive drinking. The first of these factors is psychological. Alcohol furnishes a means of escape for the immature individual who finds it difficult to cope with his environment. The second factor is concerned with a physiological reaction to its use—an addiction to alcohol as a narcotic.

*The current legal position that an individual should not be considered as a dangerous driver until the blood alcohol reaches a level of 1.5 mgms. percent is falacious. Probably the most dangerous driver on the road is the *drinking driver* who has taken enough alcohol to *impair his judgment* which is well below an amount sufficient to result in muscular incoordination and impaired and restricted vision. A drunken driver, in a medical sense, is often so far "under the influence" that he is unable to manipulate his automobile in a manner to be grossly destructive.



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## ALCOHOL AS A NARCOTIC

Ethyl alcohol acts on the human organism much as do other narcotics. The individual drinker who comes under the influence of alcohol presents symptoms which are, in fact those of a toxic (poisonous) effect on certain areas of the brain. The exact mode of action of alcohol on the nerve cells involved is uncertain but, judging from the ultimate results on the brain, this affect is that of a narcotic. This affect is similar to that of addiction to such narcotics as opium or its derivitives (heroin. morphine, etc.), *except that alcohol has a greater propensity to destroy nerve cells of the brain than any of these drugs which are generally assumed to be so dangerous in their propensities to addiction.*

In the writer's experience with the affects of alcohol on the brain covering a period of twenty-five years, it has become evident that chronic alcoholism is accompanied by a progressive deterioration of the frontal lobes of the brain. This deterioration is characterized by an atrophy of the convolutions of this lobe, which in turn is the result of a progressive degeneration of the cortical nerve cells (Courville).[1] These changes are found to be accompanied not only by changes in the personality and

[1]Courville, Cyril B.: Effects of alcohol on the nervous system of man, San Lucas Press, 1953.

character of the individual, but also by changes in his brain wave.

The degree of damage to the brain as determined by atrophy of the convolutions probably varies with circumstances; the type of beverage used (predominantly with "hard" liquors in contrast to beer and wine), the type of alcoholic indulgence (prolonged over-indulgence *versus* the periodic drinker), whether malnutrition accompanies the period of intoxication, and the individual's inherent tolerance for alcohol, as well as other personal factors.

### Accountability of the Individual in Alcoholic States

In view of these affects on the brain of the alcoholic, certain questions of legal import may be asked: What is the accountability of the alcoholic for his actions in a legal sense: How can the extent of his accountability be determined: The answer to these questions is no serious problem in the case of acute alcoholic intoxication. No one excuses the drunken driver for his acts if an injury to person or damage to property has occurred. He has voluntarily indulged in alcoholic beverages to the point where he is no longer able to control himself, and is held accountable for injuries inflicted on others.*

In a second type of acute alcoholic effect, the situation is sometimes debatable in the eyes of the court. Some individuals who indulge even in small amounts of alcoholic beverages may develop a peculiar type of amnesic episode (psychomotor attacks) marked by abnormal behavior, because the individual is out of contact with his environment, and antisocial acts may often follow. Examples have been cited (Marinacci, 1954) in which robbery, assault, and even murder have been committed after a small amount of alcohol has been ingested, entirely too inadequate to have caused a state of drunkenness. Some courts have assumed that the victim of these outbreaks was innocent of crimes produced under these circumstances, *providing he was unaware of the toxic effects of alcohol in precipitating such episodes.* If, on the other hand, this individual had had previous experiences of this kind and was aware of these effects, he should be held accountable for his acts even though, at the moment, he was out of contact with his surroundings.

### Accountability in Chronic Alcoholism

A somewhat different situation exists in chronic alcoholism. There is a considerable period of time between alcoholic bouts during which the individual is entirely rational and capable of reasoning from cause to effect. The fact that he is a chronic alcoholic cannot excuse his acts during these intervals as well as those committed under the influence of alcohol. In such cases, three courses may be followed with respect to the ultimate effects of this habituation on the brain. In the first place, the victim of chronic alcoholism may continue to deteriorate with progressive atrophy of the brain until he is no longer reliable as to his responsibility and accountability for his acts. He is not able to enter into contract regarding his own or his family affairs. He should be placed under the care of a guardian.

A second situation may also develop, particularly in the case of chronic alcoholics who are also chronically undernourished. Such individuals may be stricken with acute psychotic episodes (hemorrhagic encephalopathy). Ordinarily they are delerious and not likely to commit antisocial acts, hence these episodes usually are of no legal significance. On the other hand, true post-alcoholic psychosis of one of three types may occur. Two of these assume the form of a psychosis of a chronic type. One is characterized with physical signs of malnutrition due to lack of vitamin B (alcoholic pellagra). The second type (Korsakoff's psychosis), also due in part to malnutrition, presents a peculiar type of reaction of response to his associates (confabulation). The third form of psychosis is the result of a combination of chronic alcholism and advanced arteriosclerosis of the cerebral vessels (deteriorated alcoholic). These patients become seriously demented if they survive for any length of time.

In cases of fully developed chronic alcoholic psychoses, the individual is no longer responsible or accountable in the sense of using good judgment in the performance of their regular duties and responsibilities. Therefore, they should have guardians appointed if they are still physically well enough to be kept at home. Many of them should be placed in institutions for care, for they are beyond medical help. They are not likely to commit serious antisocial acts, however.

### Evaluation of Responsibility and Accountability

In many cases of chronic alcoholism, the time comes when a decision on the matter of responsibility and accountability must be reached. This requires the opinion of a competent psychiatrist. Unfortunately some psychiatrists are not fully aware of the damage of the brain (atrophy) as a result of chronic alcoholism, being inclined to interpret the behavior of the individual on a purely functional level. The demonstration of cerebral cortical atrophy and enlarged ventricles of pneumoencephalography (air studies) by Bennett and his coworkers,[2] presents highly significant evidence that chronic alcoholism is a brain destroyer. That this shrinkage of the brain also produces a disordered nervous function, as shown on the electroencephalogram (brain wave) is further evidence of the organic character of this deterioration.[3] Therefore, there is now available objective findings as well as psychiatric evidence to assist in determining the degree of deterioration of the brain in cases of chronic alcoholism. In case of doubt these procedures should be performed in reaching a correct conclusion.

### Summary

A new approach to the problem of legal responsibility and accountability in the case of alcoholism is based on the fact that alcohol acts as a narcotic on the brain, and when used in excess for any extended length of time will result in atrophy of this organ. This brief review discusses individual accountability with respect to both acute and chronic alcoholism. The final responsibility in the determination of the status of the alcoholic in this respect rests with psychiatrists who have become aware of the ultimate effects of alcohol on the delicate tissues of the brain.

[2]Bennett, A. E.: Presented at the Scientific Exhibit of the American Medical Association, 1956, Chicago, Illinois, under the title "Alcoholic Brain Disease".

[3]Bennett, A. E.: The value of electroencephalography in alcoholism.

# Methods of Neurologic Diagnosis and Their Critical Assessment*

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TWO opposed, but by no means mutually exclusive, attitudes are common toward neurology, and both attitudes are unwarranted: (1) Neurology is so complex, esoteric and eponymic as to be generally incomprehensible; (2) the neurologist's preoccupation with minutiae is akin to that of the medieval schoolmen with trivia; the pragmatic view obtains that the commoner diseases are easily recognized and when the clinical approach fails, special tests will yield the answer.

Neurology comprises a corpus of knowledge which in its comprehensiveness and lucidity is without peer in the clinical sciences. It is firmly rooted in anatomy, physiology and pathology, and its accomplished practice must rest on stern disciplines. As one of the clinical sciences, its principles and practice do not differ fundamentally from those of internal medicine. The neurologist has the dual task of helping in the diagnosis and the management of complex cases, and often he has the somewhat surprising duty of pointing out to his colleagues that what appears to them as simple and in no need of further investiation appears to him to be complex and worthy of the most careful study.

The amusing myth about the poverty of neurologic therapeutics to the contrary, the important progress in both medical and surgical therapy of neurologic diseases calls for great accuracy of diagnosis, as to both the seat and type of the disease. In such diagnosis special laboratory studies have assumed great importance. They are of most value when the clinical approach has been carried to its limits; they complement and supplement rather than substitute for clinical findings. The random ordering of special tests here, as in the rest of medicine, is the hallmark of the uncritical; laboratory machines are of value when they are asked the right questions rather than when used as penny-in-the-slot dispensers of abracadabra.

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## *Clinical Approach*

The twin diagnostic problems that every neurologic case poses are: "Where is the lesion?" and "what is the lesion?" To answer these fully gives the anatomic site of the lesion, the pathophysiologic disturbance, and the nature of the morbid process.

The topography of the lesion is usually decided by means of the neurologic examination. The history may also help and may at times suffice; in other patients special tests alone may provide the answer. The history reveals the site of the disordered process in jacksonian epilepsy. The patient who has a twitching starting in the thumb and index finger of the right hand, followed by similar movements of the right side of the face, has, almost certainly, a lesion at the lower end of the precentral gyrus of the left hemisphere. The aura of other types of seizure has a similar localizing value; tinnitus points to a discharging process in Heschl's gyrus, and hallucinations of smell to the uncus. Similarly, a patient who complains of symmetrical numbness and weakness in the feet and hands has a lesion of the peripheral nerves.

The greater the examiner's familiarity with anatomy the greater will be his ability to localize the lesion from the neurologic signs. When the anatomic and physiologic signs are complex, rules of thumb are not to be disdained. Vertical nystagmus tends to point to a lesion of the brain stem, fasciculations more often than not to a lesion of the anterior horn cells, and truncal ataxia to a lesion of the vermis cerebelli.

The more logical approach may be exemplified by disease of the pyramidal system. This tract stretches from the motor cortex to the lower spinal cord, crossing for the most part at the medullary pyramids. A lesion anywhere in its extent will produce essentially the same disturbances in structures distal to the lesion. The actual level of the lesion has to be determined from other signs. Thus, a cortical lesion is more likely than not to paralyze the face or an arm or a leg, or to affect them in differing severities, because the cortical areas subserving their innervation are widely separated. A lesion of the internal capsule is likely to produce hemiplegia affecting face, arm and leg. A third-nerve palsy on one side, with a contralateral hemiplegia affecting face, arm and leg, points to a lesion of the midbrain. A paralysis of the face on one side, combined with a crossed hemiplegia of the arm and leg, points to a pontine lesion; a hypoglossal nerve paralysis with a crossed hemiplegia indicates a medullary lesion. A spastic paralysis of one leg associated with an inverted radial jerk on the same side points to an ipsilateral lesion of the fifth and sixth cervical segments of the cord. A spastic paralysis limited to one or both legs may point to a lesion of either the spinal cord, most likely below the cervical enlargement, or the paracentral lobule of the brain. Presence of local epilepsy in the leg indicates a cortical seat of the disease. A sensory level in the trunk, say at the level of the umbilicus, together with a motor level, as when the lower half of the rectus abdominis muscle is paralyzed and the upper half spared, would place the lesion at about the tenth thoracic segment of the cord.

The clinician occasionally knows what disease the patient has but is unable to say exactly where it is. A patient who shows papilledema and little else is likely to have an intracranial tumor. Localization, however, may be impossible except to say that it is likely to be near the midline, causing interruption of the flow of cerebrospinal fluid in the third ventricle, the cerebral aqueduct or the posterior fossa.

### *Pathophysiologic Diagnosis*

The symptoms and signs of neurologic disease are the subjective and objective evidences, respectively, of disturbed function. This disturbance may take the form of overaction (or perverted action) of the structure concerned, or loss of its action. The chief examples of the former are the discharging lesions. In its widest connotation the discharging lesion comprehends such diverse entities as a convulsion, tabetic pain, neuralgia, the migrainous prodrome and the hiccup; in its narrower and perhaps more useful sense it is limited to the epilepsies. 'Inhibitory epilepsy" and postepileptic paralysis exemplify the second category of disturbance, the abrogation of function. Common causes are vascular disease, trauma and hypoglycemia, which interfere with the oxygen supply or the nutrition of the neurons. The loss of function may be complete, as in the cells at the center of an infarct, or partial at its periphery. It may be permanent, as when the neurons are deprived of their blood supply for more than a very short time. It may be temporary and reversible, as in Adams-Stokes disease or in the coma of alcohol or morphine poisoning.

At the simpler levels of neurologic functioning these principles apply. Thus, when a mixed peripheral nerve is cut, the muscles supplied are paralyzed, and the area innervated becomes anesthetic and remains so until the nerve fibers regenerate or compensation takes place—in the motor sphere by trick movements and in the sensory sphere by the ingrowth of fibers from neighboring areas. However, in the complex human central nervous system which has undergone progressive encephalization, destructive lesions at a higher level permit the release of functions at lower levels. These lower functional levels take time to get into operation. Therefore, the manifestations of a disease vary somewhat with the abruptness of its onset. Thus, a patient who has had a vascular accident affecting the internal capsule will manifest a flaccid hemiplegia, which, in time, progresses to a spastic hemiplegia. The patient with a cerebral tumor, gradually damaging the same area of brain, typically shows a spastic hemiplegia from the beginning.

"False localizing signs" refer to the disturbance of function at sites distant from the primary disease and occur chiefly in cases of cerebral tumor with raised intracranial pressure. Thus, in patients with papilledema, abducens nerve palsies, either unilateral or bilateral, have little localizing value. Similarly, the large pupil on the side of a subdural hematoma may result from compression of the third nerve, not by the

hematoma but as a secondary effect of herniation of the temporal lobe through the incisural notch.

*Pathologic Diagnosis*

It may at times be possible to define the morbid process from the clinical neurologic examination. More often, however, the pathologic diagnosis comes from the history, the examination of the rest of the body, or the laboratory tests.

An example of a disease which writes its signature into the neurologic examination is tabes dorsalis. The small, irregular, unequal pupils which fail to react to light but react on accommodation, the ptosis and the compensatory wrinkling of the forehead, the ataxic gait and the positive Romberg sign, the hypotonia and the impaired deep tendon reflexes, the Charcot joint and the perforating ulcer, the characteristic analgesia (over the nose, across the chest at the nipple line, in the saddle area, along the ulnar border of the forearms and on the shins) may make the diagnosis unmistakable. Similarly, the constellation of neurologic signs may point to multiple sclerosis, pseudohypertrophic muscular dystrophy, peroneal muscular atrophy, Friedreich's ataxia, general paresis or diphtheritic neuropathy, to mention only a few.

In the pathologic diagnosis, however, the clinical history generally sheds most light. It may at times supply the complete diagnosis, as in the classic case of migraine, trigeminal neuralgia, ciliary migraine, postherpetic neuralgia and a number of others. This is not to advocate neglect of physical examination. The patient whose history suggests a writer's cramp may, in fact, show evidence of Parkingson's disease. Sensory loss in the face will at once exclude the diagnosis of trigeminal neuralgia, however typical was the history for that complaint.

Many different pathologic processes may give rise to identical signs; then the history may help in the differentiation. For example, four patients have evidence of a transverse lesion of the spinal cord. In the first a history of a fall immediately preceding its onset will point to a traumatic etiology; in the second an acute onset out of a clear sky may suggest such entities as transverse myelitis; in a third a gradually progressive course associated with girdle pains may point to a spinal tumor; in a fourth an association with bilateral retrobulbar neuritis may indicate neuromyelitis optica.

In general, vascular lesions have a catastrophic or sudden onset, inflammatory diseases an acute or subacute onset; tumors are more likely to have a gradual onset and progressive course, and demyelinating disease is apt to relapse and remit.

Age of onset is important. Convulsions appearing in infancy are likely to have an entirely different significance from convulsions appearing for the first time in middle life. Raised intracranial pressure in a child is likely to suggest a tumor of a different type and in a different site from that occurring in an adult. Apoplexy in youth and apoplexy in old age raise different pathologic possibilities, even though both are due to vascular disease.

Nor must family history be neglected. Presenile dementia occurring in a patient whose relatives had Huntington's chorea, even though he himself has no chorea, is likely to be differently diagnosed from similar dementia occurring in the absence of a family history. An ataxia can be more confidently attributed to the spinocerebellar degenerations when there is a positive family history than when there is not. Optic atrophy occurring in a member of a family known to have the hereditary form of the disease will provide less of a mystery than when a sporadic case of the same disease is seen.

The neurologic examination cannot be divorced with safety from the general physical and mental examinations. That the patient is a diabetic or an alcoholic or has had syphilis or tuberculosis must receive due weight in assessing neurologic findings. That the patient has lived in the tropics, or worked as a painter, or has recently come in conflict with the law, or has sustained a compensable injury, may open up the diagnostic possibilities. An adenoma sebaceum may be the key that tuberous sclerosis is the explanation of an otherwise obscure case of mental defect and convulsions. A port-wine stain on the face may immediately illumine the otherwise unlikely combination of glaucoma, hemiplegia and seizures. Molluscum fibrosum or cafe-au-lait spots in the skin may have a definite bearing in assessing a spinal compression, an optic atrophy, raised intracranial pressure, or bilateral nerve deafness. A fading

rash in a patient with the clinical picture of encephalomyelitis will at once raise the possibility of acute perivascular myelinoclasis. Edema and redness of the skin of the face, or indeed of the whole body, in a patient who has difficulty in swallowing and weakness of the proximal limb muscles may point to a dermatomyositis. A pale, dry, wrinkled skin with loss of sexual hair may suggest a chromophobe adenoma of the pituitary as the cause of impaired vision.

Examination of the heart may reveal a source of emboli, and the blood pressure may point to an encephalopathy being hypertensive. In a patient with raised intracranial tension it may be important to establish whether a concomitant high blood pressure is its result or its cause; a compensatory hypertension is likely to be of recent origin and unassociated with a heaving, outwardly displaced apex beat.

The lung may reveal disease intimately connected with the neurologic disturbance. Empyema, bronchiectasis or a pulmonary abscess may suggest that a space-occupying lesion in the brain is a metastatic abscess. No investigation for cerebral tumor is complete without a chest x-ray to check for possible primary new growth there. X-ray examination of the lung may yield evidence which clinches the tentative neurologic diagnosis of sarcoidosis.

Disturbances of the eyes and ears are of so frequent neurologic relevance that examination of these organs is routine.

The simpler laboratory tests have the same value to the neurologist as to the internist. The Wassermann reaction of the blood, like the urine examination, is a routine procedure. It is unnecessary to labor the value of the other blood and chemical studies when indicated.

### *Mental Assessment*

Like the internist, the neurologist is often confronted with psychosomatic and functional disease. Serious errors may ensue from a wrong diagnosis in either direction. Hysteria masquerading as a neurologic disorder can present a difficult diagnostic problem; conversely, such organic diseases as paralysis agitans and temporal lobe epilepsy are frequently mistaken for psychoneuroses, at least in their early stages.

Functional disease must be diagnosed in its own right rather than because nothing can be found physically wrong. The diagnosis is irrefragable if the following four criteria are satisfied: (1) The symptoms have a functional ring; (2) there is no relevant organic disease; (3) an adequate psychogenesis can be elicited; and (4) the symptoms can be cured psychologically. None of these four canons is, in itself, adequate for a secure diagnosis. Organic tremors, for example, are often worse when the patient is under stress and can be helped by putting him at ease. There must be few people in whom the pertinacious inquirer after truth cannot establish emotion-laden complexes which can only too easily be given a spurious relevance. Bizarreness of symptomatology is often a matter of the interpreter's experience; anyone unaware of the significance of Lhermitte's sign, which is sometimes described as "water trickling down the spine," might easily attribute it to an overactive imagination, whereas the sign has a completely organic basis.

### *Limitations of the Clinical Approach*

However valuable the clinical approach, it does not permit accurate diagnosis in all cases. A tumor in the frontal lobe may simulate one in the cerebellum and vice versa. All cases of polyneuritis have a family resemblance and by and large are easily diagnosed. However, the condition has a diversity of causes, the exact one often being difficult to determine. The muscles of the hand may waste from a multiplicity of causes and the clinical examination does not always disclose which one. If rational therapy is to be applied, the progressive paraplegias of middle life require greater differentiation as to their type than is always possible by clinical means. The common diagnosis of idiopathic epilepsy when there are seizures of late onset is usually unjustified and dangerous, even when careful physical examination has revealed nothing of note. Experience teaches that migrainous headaches which always involve the same side of the head may ultimately prove to be associated with a berry aneurysm or an angioma, even when clinical signs may presently draw a blank. Subdural hematomas are great mimics and the diagnosis cannot always be excluded on purely clinical grounds. The first symptoms of metastatic tumor in the brain may bear every clinical resemblance to a vascular accident.

The neurologist is only too frequently aware that his clinical diagnosis is statistical assessment; he knows that common things commonly occur, but he knows also that a hoopoe may occasionally be mistaken for a sparrow. For these reasons, the neurologist turns hopefully to the special tests.

*Ancillary Methods*

The clinician is probably in the best position to assess contributions from the various ancillary services, for specialists of whatever sort are apt to resemble the tanner who believes there is nothing like leather. Uncritical acceptance of laboratory tests is responsible for part, at least, of the plethora of uselsss investigations; conversely, failure to recognize special contributions which the laboratory can make may handicap therapy. On the whole, however, far more patients are overinvestigated than underinvestigated. For these reasons, a forthright and judicial statement on the value of special test from the clinician's viewpoint appears merited.

It seems a sound starting proposition that when it is not necessary to do something which is expensive or potentially dangerous, it is necessary *not* to do it. The advantages of a procedure must outweigh its disadvantages, as far as these can be weighed.

The special tests to be considered are lumbar puncture, myelography, air encephalography, angiography and electroencephalography. None of these tests is entirely bland and benign, except electroencephalography, and then only if potentially dangerous activating technics are not used. Lumbar puncture occupies a separate category as a test which is routinely carried out in the general wards of hospitals or in the home. Of such "routine" tests, it is probably the one which causes the most pain, discomfort and anxiety to patients. In certain parts of the country a phobia attaches to it. The minor headaches and backaches which follow it are well known; less well known are the occasional meningitides, cranial nerve palsies, or even subdural hematomas. In the presence of papilledema, lumbar puncture is a dangerous procedure, as death may result from brain herniation through the incisural notch or foramen magnum. To carry out the Queckenstedt test in the presence of raised intracranial pressure is particularly culpable. Compression signs of a spinal tumor may be exacerbated by a lumbar puncture.

The severe headaches associated with pneumoencephalography are replaced by countervailing disadvantages when this procedure is carried out under anesthesia. The complications and occasional deaths which follow angiography are not widely canvassed. Ventriculography may aggravate the symptoms of the brain tumor it seeks to localize and immediate surgical intervention may be required.

For these reasons, before carrying out any of these tests, it is important to ask the following questions: Is this test, if results are either positive or negative, likely to add any useful information? Does the information, if useful, merely confirm the clinical evidence or supplement it? If the clinical evidence points unequivocally, for example, to hysteria, any of the tests carried out must be regarded as unnecessary. If the patient has a demonstrated carcinoma of the lung and, in addition, signs of a tumor in the brain, the majority of clinicians would probably contend that no attempt should be made to remove the brain tumor, and therefore any effort to localize it by special tests would be unnecessary. In a classic case of multiple sclerosis, many clinicians would consider a lumbar tap carried out to determine the colloidal gold reaction as a work of supererogation; those who believe that lumbar puncture can have an adverse effect on the demyelinating process would condemn it outright.

When special tests merely confirm clinical findings, the frequency of their use will depend on the clinical confidence of the physician. In a typical case of migraine, the demonstration of slow waves from the occipital area during an attack will not add materially to the diagnosis, although it is of the greatest interest to the investigator seeking to confirm or refute the theories of the pathogenesis of this desease. Likewise, in the aforementioned patient with jacksonian epilepsy starting in the thumb and index finger and spreading to the mouth, the EEG finding of sharp waves at the lower end of the precentral gyrus adds nothing new. The presence there of high-amplitude slow waves, by suggesting a space-occupying lesion for which there was no clinical evidence, would have supplementary usefulness.

### *Special Test*

*Lumbar puncture*—The usefulness of this test ranges from the absolute to the negligible, depending on the problem at issue. Generally the diagnosis of meningitis is made on clinical grounds. We are usually dependent, however, on the examination of the cerebrospinal fluid to tell what organism is involved. True, the presence of a purpuric rash may suggest a meningococcal infection, or choroidal tubercles on funduscopic examination may point to a tuberculous infection, but to omit examining the cerebrospinal fluid under these circumstances would be irresponsible. It should be added that the certain diagnosis of tuberculous meningitis depends not on changes in the chloride or sugar content of the cerebrospinal fluid, but on the finding of *Mycobacterium tuberculosis*, and the frequency with which it is found varies with the assiduity of the search. Only an examination of the cerebrospinal fluid will allow confident differentiation between a meningitis and a meningism. Since the introduction of the sulfonamides and the antibiotics, the common and sometimes inculpable habit of treating a fever before dianosing its cause can mask the classic signs of a meningitis so that it may present, for example, as a focal epilepsy. In such a case, the presence of pus in the cerrebrospinal fluid may come as a surprise, and the impossibility of diagnosing the causative organism and instituting specific therapy should serve as a caution or rebuke, depending on the circumstance. A slowly leaking subarachnoid hemorrhage may, at times, masquarade as a meningitis, or a fulminating meningitis may occasionally suggest a ruptured aneurysm. In the absence of such collateral evidence as a subhyaloid hemorrhage favoring bleeding, and an inflamed ear favoring infection, the lumbar puncture alone may establish the diagnosis.

The slight or moderate increase of cells in the cerebrospinal fluid, together with the changes in its chemical content, may not of themselves permit differentiation between a viral encephalitis, a brain abscess, a cortical thromobphlebitis, an acute disseminated encephalomyelitis, a tumor impinging on the cerebrospinal fluid pathways, or a sarcoidosis of the central nervour system. A lumbar tap early in the course of poliomyelitis may reveal no increase of cells. The introduction of foreign bodies into the subarachnoid space, as in air encephalography, may produce a transient pleocytosis.

The differentiation of a cerebral thrombosis from a hemorrhage is often notoriously difficult; however, the presence of blood or its products of disintegration in the cerebrospinal fluid will allow the distinction. The popular fallacy that blood in the cerebrospinal fluid is part of the picture of uncomplicated subdural hematomas must be exploded.

A positive Wassermann reaction in the spinal fluid, together with a pleocytosis, increased globulin and protein content, and a paretic colloidal gold reaction, almost permits the diagnosis of general paresis from the lumbar tap alone; but all these positive findings are not invariably found together. A completely normal spinal fluid is compatible with the diagnosis of tabes dorsalis. A paretic colloidal gold reaction (with a negative Wassermann reaction) may permit the diagnosis of multiple sclerosis when this disorder has to be diffentiated from the myelopathy of cervical spondylosis. But a paretic curve may also occur in nonsyphilitic subjects in other diseases than multiple sclerosis, such as sarcoidosis of the nervous system and the encephalitis associated with acute specific fevers.

In unskilled hands the organisms of a torula meningitis may be mistaken for white blood cells. In skilled hands malignant cells may be detected. The cerebrospinal fluid sugar may be low when there is a spinal fluid pleocytosis from causes other than infectious disease.

*Electroencephalography*—The value of this tool in research has been great; its usefulness clinically, though undisputed, is more circumscribed. Only in the epilepsies can it be said to yield information of a type that cannot be ascertained from the clinical examination and other special tests. As in all types of inquiry, the amount of information gleaned will vary with the skill, pertinacity and ingenuity of the examiner. Many of the disturbances of the brain susceptible to recording are episodic, so that, generally speaking, the longer the record the more chance of picking up such abnormalities. The skilled use of activating technics, such as hyperventilation and sleep induction and photic stimulation, will hasten and enhance the possibilities of finding disturbances.

In epilepsy, the problem the clinician puts to the electroencephalographer is

whether it is the so-called idiopathic type or secondary to an insult to the brain; and if damage exists, where is it? If three per second, bilaterally synchronous spike and wave discharges can be demonstrated, the clinician can rest assured that he need not further pursue investigations for serious organic disease; it may also point up to him that the oxazolidine-2, 4-dione derivatives may have a specific therapeutic effect. It is especially important when surgery is contemplated to know whether the brain damage is localized or widespread. As a guage of improvement, there is not always a close correlation between the clinical and electro encephalographic status.

In cases in which clinical evidence is sufficient to indictate the likelihood of a tumor but insufficient to lateralize or localize it, the EEG may do both. It is not within the competence of the machine to tell the nature of a tumor; the amount of slowing of the waves, however, may indicate the acuteness of the space-occupying lesion and by that means hint at its nature. It may also confirm a lesion otherwise in doubt; it may reveal the presence and position of an otherwise unsuspected metastatic tumor in the brain of a patient with a primary lung carcinoma. Occasionally the type of dysrhythmia may be fairly characteristic for a specific disease, as in the case of subacute sclerosing encephalitis.

*Radiology—Plain x-rays—* Some Physicians order plain x-rays of the skull in patients with suspected neurologic disease almost as often as they order chest x-rays when lung disease is suspected. The information yielded in these two instances is not comparable; the lung itself can be visualized but not the brain unless there is calcification. Conclusions must be drawn for the most part from changes in the skull. Where trauma is involved, x-rays are imperative for medicolegal reasons, even though there is little correlation between the presence or absence of fractures and the seriousness of the damage to the brain. A fracture involving the groove of the middle meningeal artery may, however, have more precise value in supporting the diagnosis of an extradural hemorrhage.

In cases of suspected tumor or other space-occupying lesions, such as subdural hematomas, a calcified and shifted pineal gland may strengthen the diagnosis, as may a similar shift in a calcified falx or choroid plexus. A tumor may itself be calcified or it may produce erosion or hyperostosis of adjoining bone. An acoustic neuroma may be seen on suitable views to excavate the internal auditory meatus; a glioma of the optic nerve may enlarge is optic foramen; and a chromophobe adenoma may produce characteristic ballooning of the pituitary fossa, while the eosinophil adenoma produces additional changes in the skull and jaws. The plain x-rays may localize and even go far in identifying the type of tumor. A completely normal skull x-ray is, of course, not incompatible with a brain tumor. Erosion of the dorsum sellae, or in a young person separation of the sutures, will provide evidence of raised intracranial pressure.

In vascular disease x-ray of the skull also has a sphere of usefulness. Vascular calcification may occur in arteriosclerosis; aneurysms may show an arc of calcification in their walls; a chronic subdural hematoma may show plaques of calcification around it; in the Sturge-Weber syndrome "tramline calcification" may be in evidence. A retro-orbital aneurysm may erode the margin of the opic foramen or the sphenoidal bones at the upper end of the orbital fissure. The radiologist may also help in the diagnosis of toxoplasmosis or tuberous sclerosis, both of which are often characterized by nodules of calcification.

The help from competently executed and interpreted x-rays must be set against the countervailing errors and dangers ensuing from attaching pathologic significance to the many and varied deviations from the normal which have no clinical significance. The field of neuroradiology has grown rapidly and is attracting its own specialists. Here, as elsewhere, there is a wide gulf between the expert and the average.

Roentgenography of the spine is of great importance to the neurologist. In little more than a decade the condition formerly called cervical osteoarthritis, considered of little clinical significance, has blossomed, under the new name of cervical spondylosis, into the most common cause of myelopathy in the second half of life. It also has been incriminated in sensory and motor disturbances of the neck and of the limbs, and it has been found to underlie some cases diagnosed as diversely as frozen shoulder, subarachnoid bursitis, atypical coronary artery disease, and carpal tunnel syndrome. Unfortunately, the severities of the radiologic findings and the neurologic disorder in cervical spondylosis are not closely correlated.

In recent years the importance and relative frequency of diseases at the junction of the spine and skull, such as platybasia, occipitalization of the atlas and fracture of the odontoid, have been increasingly recognized. They have been found to explain cases of so-called degenerative spinal cord disease and of atypical multiple sclerosis and primary lateral sclerosis. On the other hand, the neurologic significance of such conditions as cervical rib and spondylolisthesis has waned. It need hardly be added that radiologic changes elsewhere in the body, for example in the lung, the pelvis or the elbow, may have great neurologic importance.

*Air encephalography*—When air is introduced by the lumbar route, a pneumoencephalogram is obtained; when it is introduced directly into the lateral ventricles through bur holes in the skull, a ventriculogram results. The former procedure is generally preferable as being simpler and yielding more information, since it allows the air to pass over the surface of the brain and into the various subarachnoid cisterns as well as into the ventricles. However, it entails considerable risk in the very condition in which air encephalography is likely to be of most value—a cerebral tumor—for it has all the dangers inherent in lumbar puncture. Not that ventriculography is entirely safe in these cases either; a tumor of the posterior fossa may cause upward herniation of the cerebellum through the incisural notch as the result of the ventricular tap. However, the surgeon is at hand to deal with this emergency.

Even when the tumor has been confidently localized on clinical or electroencephalographic grounds, or by means of plain x-rays, air studies are still valuable in outlining its extent, which is often much greater than the area with whose function it interferes. Although the principles of localizing a tumor by air encephalography are relatively simple, sometimes it is not easy to distinguish an expanding lesion in one hemisphere from an atrophic lesion in the other.

However valuable air studies are in demonstrating an expanding or atrophic lesion of the brain, they do not often tell much of the actual nature of the lesion. A combination of abnormalities, such as ventricular compression and shift toward the opposite side combined with inability of the air to pass over the hemisphere on the same side, may raise the strong possibility of a subdural hematoma. Likewise, the presumption is strong, when a tumor is demonstrated in the third ventricle near the foramen of Monro, that a colloid cyst is involved because there is no other likely lesion in that position. To demonstrate cortical atrophy in a case of dementia, is not to continue the diagnosis very much farther, for there are many conditions which may produce both. Demonstration of several filling defects may suggest that the lesions are metastatic.

*Angiography*—This technic has added a further dimension to neurology. With its aid, occulsion of the internal carotid artery, a disease anticipated by Ramsay Hunt in 1914, was firmly defined by Moniz in 1937. The accurate localization of berry aneurysms has opened new possibilities for their surgical cure. Angiography has shown that angiomas are responsible for a larger percentage of subarachnoid hemorrhages than had been formerly thought. The accurate identification of an anterior choroidal artery by its means may ease the task of the neurosurgeon seeking to treat Parkinson's disease by ligating that vessel. It has also opened up new possibilities in the treatment of cerebrovascular disease; attempts are already being made to replace damaged blood vessels, and intracerebral hematomas now invite less conservative therapy than in the past.

In the diagnosis of diseases of the blood vessels, with the possible exception of hematomas, angiography is obviously preferable to air studies. However, the respective merits of the two technics in the investigation of tumors are less easily decided and will depend on the preferences and experience of the physician concerned. In lateralizing a tumor, air encephalography is usually preferable; in localizing a tumor in a known hemisphere, angiography has the merit that it will give additional clues as to the tumor type. Often the two studies complement each other.

*Myelography*—A wisely critical attitude to this much-abused test seems to be on the increase. The frequency with which patients with functional backaches forget the reason that led to their spinogram and fasten on it as the cause of their subsequent pain has led to a certain caution in its use "just to make sure that no organic disease is present."

Increasing conservatism in the treatment of disk disease has brought, as a corollary,

the view that the accurate outlining of a herniated disk that is not to be operated on smacks of the academic. Demonstration of an apparent spinal block or an appearance suggestive of arachnoiditis, when the test is done within a few days of another lumbar puncture, only too frequently fails to suggest to the unskilled that the injection may be subdural. The beguiling hope that myelography will always differentiate a transverse myelitis from an acute compression of the cord may turn to bemusement when it demonstrates a block, yet the surgeon fails to find any cause of extramedullary compression. The myelogram may fail to reveal a lesion within its competence because of the clinical failure to realize that a sensory level, for example, may be due to a lesion at a very much higher level than the apparent segment of involvement. Once again the machine has been asked a wrong question.

*Conclusions*

Advances in the methods of neurologic diagnosis have been substantial. Each new advance, however, seems to pose new problems and each new window to open up fresh vistas of ignorance.

The clinical examination remains of fundamental importance. Special tests, wisely used, supplement and complement that examination. Only too often, however, the cases that are puzzling to the clinician are equally bewildering to the radiologist and the electroencephalographer. Search continues for the special test that will replace clinical doubt by certainty.

Despite all our advances, the challenge of accurate diagnosis remains. Experience continues to be fallacious and judgment difficult.

# The Investigation and Interpretation of Head Injuries*

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THE investigation of death from head injuries forms a significant proportion of the cases in any practice of forensic pathology. Although it is not always appreciated, the correct interpretation of the findings can be of considerable value in assisting courts to arrive at a proper decision in both civil and criminal cases. Moreover, although eye witnesses may be deceived or deceive, dumb evidence cannot lie and is only subject to human error in interpretation. The latter is usually due to inexperience or to subconscious selfdeception. The following case shows the danger of a prejudiced eye witness:

"A man was fatally injured as a result of impact with a police car. Eye witnesses in this part of the city were 'police-allergic' and said the car had run him down. Subsequent reconstruction from injuries to the man and damage to the car revealed the truth—that he had walked into the side of the car."

The value of reconstruction is not restricted to legal medicine, for a knowledge of the mechanism which caused an injury can aid the clinician in diagnosis and treatment and in making a prognosis. It is obvious that a correctly conducted investigation of any head injury, whether the injured person is alive or dead, requires the same approach as does that of any other traumatic lesion.

Although a detailed history of the injured person may be of considerable value, it should be studied *after* the examination; otherwise, the examiner may have a proconceived idea into which he subsequently fits his facts. It usually is unwise to place too much importance on the history unless it is confirmed by evidence based on visual observations of the patient before and after death. This is stated unequivocally, because there is always the danger that the history may be incorrect and that the examiner may be subconsciously misled. A more practical aspect is that the examiner becomes so accustomed to relying on the history that he may find himself in difficulty when none is available.

### *Technic of Investigation*

The technic of acquiring the necessary data in investigating head injuries may be divided into the following stages. This procedure has proved to be of considerable value, as it affords an opportunity for reexamination at a later date.

*Stage 1*—A general examination is conducted of the clothed body and then of the unclothed body to obtain information regarding such detail as direction of impact. At this stage, many pathologists err, because they fail to examine the clothed body. The presence of material such as glass, flakes of paint, or oil may be of considerable value in reconstructing an accident or in identifying a vehicle. Much valuable evidence on the clothing may be lost through careless handling or destruction. Another error is to allow the body to be washed, as marks and trace evidence may be lost.

The general examination may be of great assistance in assessing traffic accidents, which are the cause of a large proportion of head injuries. Figure 1 shows what may be expected from a sideways impact in a person crossing the road; figure 2 shows the results of an impact from behind.

Injuries can be divided into those of primary impact, caused by the vehicle itself, and those of secondary impact, caused by the person's striking the ground, some

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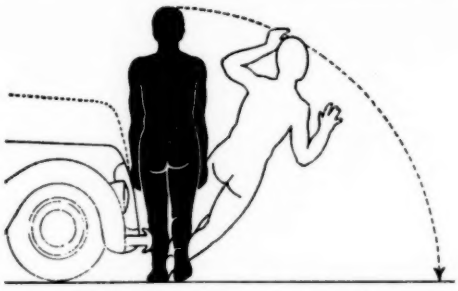

FIGURE 1. Impact from the side.

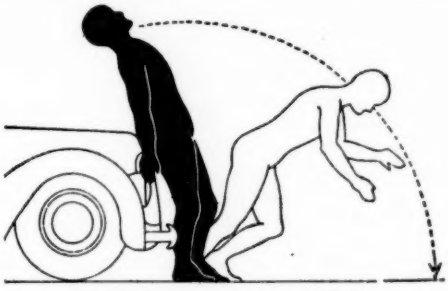

FIGURE 2. Impact from behind.

other object, or even the vehicle a second time. Since trauma to a fixed head causes a different type of lesion than does injury to a moving head, it is essential to distinguish between injuries caused by primary impact and those caused by secondary impact. Sometimes both injuries may have occurred.

Injuries from primary impact on any body often can be identified from their character and site, which may indicate the points of contact with the vehicle. Certain characteristics may indicate injuries resulting from secondary impact. In the case of assault by blunt or sharp weapons, the presence and site of characteristic defense injuries on the hands or arms may be of assistance in identifying the instrument. Bruising on the face may indicate a blow which has caused loss of balance and consequent impact of the head against the ground. Examination of the eyes, ears, nose and mouth is essential to exclude or indicate any significant disability such as impaired vision or hearing, while a wasted or deformed limb may have caused a fall.

*Stage 2*—All injuries on the face and scalp should be examined, and it should be remembered that they may be caused by striking an object or by being struck. Such lesions may include bruises with or without abrasions. Bruises may show first merely as swellings or tenderness, but there may be some characteristic pattern, such as the weave of the material of a head covering or floor covering, if such was interposed between the scalp and the cause of the trauma. Sometimes, there may be no external evidence of bruising, and it is revealed only at autopsy.

Impact of the head against some hard surface usually will produce a small irregular laceration, while crushing may cause bilateral bruising. A blow with a blunt instrument can produce a stellate laceration and a linear object, such as a metal bar, will produce a Y-shaped laceration. Sometimes, knowledge of the nature of the intracranial damage may be essential in order to reconstruct the incident, for lesions in a fixed head will differ considerably from those produced by deceleration impact. The shape of the lacerations may identify the agent which caused the injury, for example, a hammer. Careful exposure and examination of the pericranium or outer table of the skull may confirm the impression gained from the wounds of the scalp. The scalps of children may not be lacerated and may merely show abrasion.

Incised and puncture wounds are due to a sharp edge or a point. The absence of denudation of hair at the edges of the wound or the presence of bridging and of hairs forced into the wound helps differentiate wounds of this type from lacerations. Puncture wounds caused by a sharp point usually will cause similar injuries to the underlying pericranium and bone.

Compound fractures of the skull may cause lacerations of the scalp which may be confused with those resulting from the impact which produced the fracture. Linear fractures will afford evidence of the direction of force, and fractures by contrecoup may occur and must always be considered.

**The site of the injury may be significant.** The top of the head may be injured when the head butts some object or when a person falls headfirst. However, an injury in this area is usually due to some blow striking the top of the head. The occipital region is commonly injured by falling backward. The character of the skin lesion and fracture and the site of the cerebral lesions will help avoid confusion with blows on the occiput. A bruise of the scalp above

and behind the ear in the parietal region with a fissure fracture into the middle fossa commonly is caused by a secondary impact when a person is knocked down by an automobile. Splitting lacerations of the eyebrow, cheek or the lips alone are usually due to a localized impact, such as from a fist or boot. When such lacerations are caused by the face striking the ground, other abrasions on prominent parts of the face will be present. Knuckle-dusters or other hard objects in the hands of an assailant may cause bone injuries which are far more serious than would be expected even from a boot.

*Stage 3*—The next step involves examination of the pericranium and the cranium (outer table). Extensive pericranial hemorrhage (floating scalp) usually is associated with springing of the sutures, but small children, whose scalps are loose, may have an extensive hematoma from relatively little trauma. Occasionally, rupture of the sinus may occur.

As previously mentioned, the surface of the outer table of the skull may show marks which will identify the weapon. These will coincide with wounds on the scalp. They may be in the form of tangential or vertical cuts, as from a chopper or heavy knife; indentations, as from a hammer; or tangential "egg-top" lesions, caused by impact of the head against an edge. There may be a linear depression, as caused by a cosh, or circular depressions in the case of infants. There may be springing of the sutures with or without fissure, comminuted and depressed fractures. A wound from a beveled projectile is classic.

*Stage 4*—When further information may be obtained from examination of the inner table, the calvaria should be removed. Caution should be taken against indiscreet use of the hammer. An extradural hemorrhage will be obvious, and the dura mater may be tense and on incision reveal an underlying subdural hematoma or severe edema. If the dura mater is ruptured, cerebral herniation will result. A subarachnoid extravasation of blood is usually present, even when there is no obvious cerebral laceration or contusion, but it must be differentiated from congestion. If there is bleeding localized to the base of the brain, an aneurysm always should be suspected. A chronic subdural hematoma (sometimes bilateral) may be present with old adhesions, although it also may be spontaneous. Sagittal sinus thrombosis always must be considered, for this condition in young children has been mistakenly diagnosed as traumatic contusion.

*Stage 5*—The next procedure requires removal of the brain and examination of the base of the skull before and after stripping of the dura mater. An extradural collection of blood may be found. Extension of fissure fractures in many sites will be easily identified, and some may be traced onto the vault which has been removed. The orbital plates commonly show fractures by contrecoup in occipital deceleration injuries.

*Stage 6*—The surface of the unfixed brain should be examined. After it has been photographed, the brain should be fixed before cutting, by suspension in 10 per cent FORMALIN® saline from the basal arteries to avoid distortion. The length of time allowed before the brain is cut may have to depend on the urgency of the situation.

At this stage, one should consider the differentiation between trauma and natural disease, especially the possibility of a berry aneurysm which may be on the internal carotid artery. Natural capsular hemorrhages also may rupture onto the surface with subdural hematoma. The sites of contusions and lacerations may be extremely important when differentiating between injuries which occur during deceleration and those of direct impact to a fixed head. Lacerations of the frontal pole with fractures of the occipital bone denote deceleration, and injuries of the occipital pole with fractures of the frontal bone also are usually easy to interpret. The possibility of two independent injuries must be considered, and they should be identified from lesions of the scalp. Uncal and tonsillar herniation will indicate the amount of intracranial tension; but the interpretation of tonsillar herniation should be undertaken cautiously, for postmortem or antemortem posture may be a contributing factor. The amount of flattening of the convolutions may also be of importance.

*Stage 7*—After fixation, the extent and sites of the brain damage, such as contusion of the falx or damage of the corpus collosum, are determined, and edema is noted. Examination should be made for secondary effects, such as brain stem and midbrain hemorrhage and thrombosis, which invalidate recovery. There should be little difficulty differentiating between these and

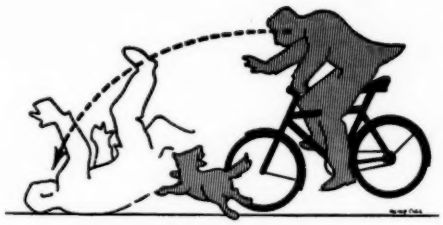

FIGURE 3. Fall from bicycle.

shear injuries. Old vascular lesions or a deep aneurysm also may be identified. A histologic examination should be made of doubtful lesions.

### *Use Of Information*

After collecting the necessary data, the case may be assessed with a view to establishing the following facts: (1) the mechanism of the injury and the nature of the impact, e.g., primary against a rough object, secondary against a rough object, or direct impact by a blunt object, and if possible, some indication of the type of object; (2) the degree of force and direction of the impact; (3) whether there is more than one injury; and (4) the speed of loss of consciousness, the degree and length of unconsciousness, and the rapidity of death, all of which may help establish how much, if anything, the person could have done after the injury.

### *Case Reports*

The following cases, which have been investigated during the past few years, illustrate some of the aspects previously discussed in the interpretation of head injuries.

*Case 1*—Injury with a blunt instrument—A 44 year old man was alleged to have been struck on the head by a cricket bat wielded by his stepson. Preliminary examination at autopsy showed very little external injury to the scalp. However, bruises on the forearms and hands showed abrasion patterns that could have been caused by the binding of a cricket bat. Reflection of the scalp revealed extensive comminuted fractures of the vault of the skull on the right side, localized trauma below the fractures, and subarachnoid and subdural hemorrhage.

It was concluded that the injuries to the skull were consistent with direct impact by some blunt instrument with a fairly broad surface. Although the injuries to the skull and scalp did not prove that the alleged weapon had been used, the injuries to the arms were typical defense injuries and showed marks similar to those which would be produced by the bat.

*Case 2*—Injury to a fixed head by a blunt instrument—A 42 year old man formed an association with a prostitute without knowledge of her profession. Later, he became disillusioned, and in a fit of jealousy or revenge stabbed the girl in the back. He then fled, but was pursued by her friends who eventually tripped him. During the ensuing proceedings, he received head injuries believed to have been caused by a piece of concrete. He was taken to hospital where he underwent a craniotomy and removal of part of a comminuted depressed fracture at the back of the skull. He subsequently died. Examination at autopsy showed that in addition to the injury caused by striking the ground, the opposite parts of the skull had been injured without contrecoup. This indicated that the man had sustained injuries from impact to the fixed head. The injuries were consistent with the head having been struck while on the ground by some heavy object, such as a piece of concrete.

*Case 3*—Tangential injury to the skull—While playing on the ropes of a gymnasium, a 14 year old boy fell on his head and was temporarily stunned. He was taken to hospital at 8:30 p.m. and remained there for an hour, during which period he was fully conscious. Roentgenographic examination did not reveal a fracture. He went to bed at 10:30 p.m. and was found dead at 7:55 a.m.

At autopsy the pupils were equal and half dilated. No external injury of the scalp was visible, but reflection of the scalp showed a fracture running into the right middle fossa and involving the middle meningeal artery. There were a large extradural hematoma, flattening of the brain, and slight local contusion. No secondary pontine hemorrhage was noted. There had been respiratory failure with gross pulmonary edema.

The injuries were typical of a fall on the head without deceleration. The case followed the classic history of an extradural hemorrhage and exemplified the importance of keeping patients with this type of history under observation for the first 24 hours. *Case 4*—A deceleration injury—A

## TABLE 1

INCIDENCE OF FRACTURES OF THE BASE OF THE SKULL IN PERSONS EXAMINED AT AUTOPSY AT THE LONDON HOSPITAL MEDICAL COLLEGE, DEPARTMENT OF FORENSIC MEDICINE, 1953-1958

| TYPE OF ACCIDENT | YEAR | SITE OF FRACTURE | | |
|---|---|---|---|---|
| | | *Anterior fossa* | *Middle fossa* | *Posterior fossa* |
| Pedestrian | 1953 | 6 | 19 | 5 |
| | 1954 | 3 | 9 | 3 |
| | 1955 | 6 | 17 | 3 |
| | 1956 | 12 | 19 | 8 |
| | 1957 | 1 | 4 | 2 |
| | 1958 | 6 | 15 | 4 |
| Falls | 1953 | 5 | 5 | 2 |
| | 1954 | — | 1 | — |
| | 1955 | — | — | 2 |
| | 1956 | 2 | 3 | 3 |
| | 1957 | — | 2 | 3 |
| | 1958 | 4 | 9 | 9 |
| Motorcycle | 1953 | 5 | 9 | 2 |
| | 1954 | 6 | 4 | — |
| | 1955 | 2 | 6 | 1 |
| | 1956 | 5 | 10 | 4 |
| | 1957 | 6 | 8 | 3 |
| | 1958 | 2 | 7 | 3 |
| Pedal cycle | 1953 | — | 3 | 1 |
| | 1954 | 1 | 5 | 4 |
| | 1955 | 1 | 6 | 1 |
| | 1956 | — | 3 | 4 |
| | 1957 | 5 | 7 | 2 |
| | 1958 | 1 | — | 1 |
| Motor vehicle | 1953 | — | — | 1 |
| | 1954 | — | 2 | — |
| | 1955 | — | 1 | — |
| | 1956 | 3 | 2 | 2 |
| | 1957 | 4 | 2 | — |
| | 1958 | 3 | 5 | 3 |
| Miscellaneous | 1953 | 9 | 29 | 5 |
| | 1954 | 8 | 18 | 13 |
| | 1955 | 5 | 22 | 6 |
| | 1956 | 8 | 16 | 5 |
| | 1957 | 5 | 17 | 3 |
| | 1958 | 7 | 15 | 3 |

62 year old man was admitted to hospital after falling from his bicycle (figure 3). He was unconscious and was transferred to a neurosurgical unit where parietal burr holes were made and 30 cc. of subdural clot was evacuated from over both hemispheres. This caused some improvement in the level of consciousness. Roentgenograms of the skull and chest showed an oblique linear fracture through the parietal and squamous temporal regions on the left side and fracture of the second, third and fourth ribs also on the left side. The patient died 10 days after the injury.

Findings at autopsy were: (1) an abraded bruise in the left temporal region; (2) a linear fracture reaching into the left middle fossa; (3) contusions of the left and right temporal and right frontal lobes with edema and necrosis; and (4) pulmonary embolism due to bilateral phlebothrombosis of the veins of the calves. These injuries are typical of deceleration injuries due to a fall on the side of the head. Such injuries are very common in people knocked down by automobiles. The terminal pulmonary embolus is a common complication of head injury.

This last case draws attention to the relatively high incidence in England of fractures of the middle fossa resulting from automobile accidents. Tables 1 and 2

TABLE 2

SITE OF FRACTURES OF THE SKULL IN PERSONS EXAMINED AT AUTOPSY AT THE LONDON HOSPITAL MEDICAL COLLEGE, DEPARTMENT OF FORENSIC MEDICINE, 1953-1958

| SITE | 1953 | | 1954 | | 1955 | | 1956 | | 1957 | | 1958 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Cases* | *Percent* | *Cases* | *Percent* | *Cases* | *Percent* | *Cases* | *Percent* | *Cases* | *Percent* | *Cases* | *Percent* |
| Anterior fossa | 25 | 19.9 | 18 | 19.4 | 14 | 15.7 | 30 | 21.9 | 21 | 23.8 | 23 | 19.3 |
| Middle fossa | 65 | 51.5 | 39 | 42.0 | 52 | 58.5 | 53 | 38.7 | 40 | 45.5 | 51 | 42.8 |
| Posterior fossa | 16 | 12.7 | 20 | 21.5 | 13 | 14.6 | 26 | 19.0 | 13 | 14.8 | 23 | 19.3 |
| Posterior and middle fossae | 10 | 7.9 | 9 | 9.7 | 5 | 5.6 | 10 | 7.3 | 4 | 4.5 | 9 | 7.6 |
| Anterior and middle fossae | 10 | 7.9 | 7 | 7.5 | 5 | 5.6 | 18 | 13.1 | 10 | 11.4 | 13 | 10.9 |
| TOTAL | 126 | | 93 | | 89 | | 137 | | 88 | | 119 | |

show the results of head injuries found at autopsies carried out by the Department of Forensic Medicine at The London Hospital Medical College during 1953 to 1958, inclusive. It will be noted that fracture of the middle fossa occurs more frequently than does fracture of the posterior or the anterior fossa. This conforms with findings in England where head-on impacts, except by drivers of motorcycles, are less common than in North America, and where more pedestrians are killed in accidents involving motor vehicles than are drivers.

## *Summary*

The procedure outlined here for the routine examination of persons who die from head injuries complies with the Coroner's Rules (1953), which state that the material on which the cause of death is based shall be retained after autopsy. The use of photographs and the retention of the brain for fixation before the final dissection make it possible to refer to previous cases and their interpretation and provide an opportunity for representatives of interested parties in both civil and criminal cases to see the material.

ACKNOWLEDGEMENT

I should like to record my appreciation to the various coroners and clinicians who have allowed me to use their material and records, to S. A. Day and A. J. Hardy, who have been responsible for the photographs and preparation of the material, and to Mrs. E. Sanders, who prepared the statistical evidence from our punch card records.

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# Impartial Medical Testimony

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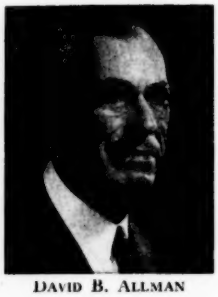
*The following discussions, reprinted by permission from Postgraduate Medicine, Vol. 26, No. 1 and No. 2, July and August, 1959, concern the need for impartial medical testimony. These discussions were presented before a Conference on Costs of Personal Injuries, sponsored by the Chicago Association of Commerce and Industry and the Medical Directors Club of Chicago.*

*Dr. Allman is the immediate Past President of the American Medical Association; Mr. Smith is General Counsel, Kemper Insurance Companies; Mr. Roddewig is President of the Association of Western Railways; Dr. Viko is affiliated with the Inter-Mountain Clinic; and Dr. Wade is Chief, Traumatic Surgery Section, New York Hospital.*

***Statement by Dr. Allman:***



DAVID B. ALLMAN

I FIRST would like to emphasize that I definitely favor impartial medical testimony. In fact, I believe in it so strongly that I sometimes become disturbed at the misuse of the phrase. In some circles, both medical and legal, the expression is used so as to imply that medical testimony usually is not impartial.

I am a doctor, and my professional life depends on my judgment. Whether it is expressed in my office or in court, my medical opinion is what I honestly believe. It is based on all I've been taught, on all I've learned, and on all I know. In my practice, my reputation and the welfare of my patients depend on my opinion and my judgment. When I'm on the witness stand as a doctor, I do not change character, nor do I alter my opinion for whim, caprice or financial gain.

I believe in impartial medical testimony. I further believe that doctors and attorneys should educate themselves and the public concerning the meaning of this expression. Too many lawyers and judges believe impartial medical testimony means testimony procured only through court-appointed experts or that with which all doctors agree. Too many doctors think impartial medical testimony will free them from their obligations as citizens to appear as witnesses in our courts.

The New York Impartial Medical Testimony Plan has been a valuable experiment. It has certainly demonstrated that it can be utilized to advantage in that geographical area. It has provided a means of resolving differences of medical opinion when error causes one opinion to be incorrect. It has acted as a method for curing mistakes made by lazy, careless, inefficient or incompetent doctors who call themselves "expert."

Outside our own bailiwick—in the courtroom instead of in the hospital—physicians sometimes feel "lost". Whatever the reasons may be, we do not prepare for the role we must play as witnesses. When we do not prepare, our testimony is likely to be unsound, unscientific, biased, incomplete, incompetent, irrelevant and immaterial. Insofar as the presentation of medical or other testimony is concerned, it is unlikely that our judicial system will be altered to any major degree in the

foreseeable future, nor do I believe that it should be. The adversary procedure is ingrained in our culture. We should live with it and encourage such modifications and improvements as the structure will accommodate.

The physician is obligated to himself, to his profession, and to the public to cooperate with the legal profession and the judiciary in providing sound, impartial medical testimony under whatever mechanism exists in his particular geographical area. The physician must appreciate that frequently there are persons whose entire futures are involved in a litigation, and that there are lawyers representing these persons, a jury seeking enlightenment, and a judge administering the proceedings.

Organized medicine believes and has cautioned the physician that he has only himself to blame if he examines casually and testifies without adequate knowledge and, as a result, is cross-examined bitterly, or if he gives a superficial exploration and it is contradicted by a colleague who has properly prepared himself. If he succumbs to sympathy, friendship or misplaced loyalty and if his testimony consciously or unconsciously seems to favor one side or the other, the offending physician has not only discredited himself and his profession but also has obstructed the proper administration of justice.

Yes, I believe in impartial medical testimony. I believe in statements of fact and opinion under oath by a doctor who is honest, conscientious and informed. The doctor owes no more than this to justice, but he *does* owe this and all it implies. Every doctor who serves as a witness should have enough personal pride, professional competence and good sense to prepare for and to give his testimony so that all who hear or read must say, "There is a man. Would that all were like him."

I am not so naive as to expect all doctors to seek this ideal. I can hope—and I do sincerely hope—that more and more doctors will strive for it. I also hope that the legal profession will soon awaken to the unethical activities of the "legal procurer" who solicits, urges and encourages the otherwise honest physician to pervert his testimony.

In the published report of the first two years of operation of the New York plan, several examples of poor medical testimony were given. For instance, in 24 of 100 cases involving interpretation of x-rays, the panel experts detected material error. This erroneous testimony does not seem to me to represent partiality as much as it represents incompetence or, perhaps, even dishonesty. The testimony of a panel of experts should not be necessary in the usual fracture case to assure the court and jury that there really was a fracture.

I think that it is right and proper for doctors to disagree regarding diagnosis and therapy, providing the facts on which each is based are thoroughly known. It would be deplorable if uniformity of judgment were imposed on us. But note well, I said I champion diversity of opinion when all the facts are known. I also believe independence of medical judgment must be preserved. The fact that one physician would employ different diagnostic technics or use a different therapy than I does not mean that either or both of us are in error. Medicine is not an exact science.

The reputation of medicine and the reputation of the doctor must be re-established so that the court and jury can accept medical testimony. I believe that a project such as the New York program is the best available temporary solution to the problem of impartial medical testimony.

***Statement by Mr. Smith:***

CHASE M. SMITH

FACTORS that relate to impartial medical testimony have a decided impact on our economic and social life. To an insurance lawyer, the words "medical testimony" bring to mind claims for injuries due to automobiles and other accidents, cases of accident and disease which are contested under the workmen's compensation laws, and arguments regarding the existence or the character of injuries or sickness for which claims may be made under accidents, health or, possibly, life insurance policies.

Not only are accidents regrettable, but the developments and trends in claim costs have an increasingly ruinous effect on our daily lives and businesses. We read of sensational cases, such as a $400,000

verdict for injuries in a train wreck, a $240,000 settlement to an ex-waiter, etc.; however, in my own experience, the average claims are small. In our company, 71 per cent of the claims for bodily injury from automobile accidents are estimated at under $500. In well-managed companies, only a small percentage of claims are litigated. However, voluntary settlements are influenced and, to a degree, controlled by the results in contested cases. In the last 10 years, the average cost of claims resulting from automobile injuries doubled.

Rising claim costs result in increased costs of insurance premiums. In 1940, the public spent $288 million for automobile personal injury insurance, compared with over $2 billion in 1957. Between 1950 and 1957, automobile insurance premiums increased two and one-third times, but the number of registered automobiles increased by only 40 per cent. The difference in the proportion of increase between claim costs and insurance premiums is accounted for by the cost involved in investigating cases, medical expenses, accident prevention work, etc. In recent years, insurance companies have had tremendous losses not balanced by increases in automobile and other liability insurance premiums.

Rising wage levels and living costs and inflationary influences have some effect on the increasing claim costs, but I believe the chief reason for this problem is the irresponsibility or lack of judgment and good citizenship on the part of the public and of our judicial, legal and medical systems. If ever this problem is solved, the solution will be effected by (1) public education in civic responsibility and economics and (2) steps to improve the part played by the professional systems mentioned.

We must point out to the public the practical result of irresponsibility in this field. The costs of unjustified claims are reflected in the costs of food, rent, clothes, medical care, etc., thus preventing people from enjoying the necessities and luxuries of life. Increasing claim costs interfere in countless ways with the easy and natural course of progress which has resulted in the development of the things which bring us happiness.

From every point of view, exaggerated and spurious claims and irresponsible conduct on the part of our legal and medical systems create a situation which must be remedied. One possible answer is to seek the testimony of impartial medical witnesses. Medical treatment and testimony are factors of utmost importance. Even in cases in which there is a simple and absolute answer to medical conditions, there is still an infinite number of controversies based on fault, time, value and a hundred other factors. A doctor can estimate the time of disability, but he can't say what a man's time is worth. He can estimate the degree of pain and suffering but he can't say what it will cost a patient.

Under the leadership of Judge David W. Peck, significant developments have been made in the field of providing impartial medical testimony in the state of New York. Some believe it is effective in speeding up cases, in raising the standards of medical testimony, and in achieving fairer results. This plan has substantial but not unanimus support. I believe the project will result in improvement, but it should be worked out with great caution. Miracles cannot be expected.

In any event, I would say that until the general public has better understanding of economics and a recognition of civic responsibility, we can never settle this problem of liability satisfactorily in this country, where freedom is founded on respect for law based on the constitution and where the people are or should be the government. There is some reason for hope; in fact, recent developments—including a better record in defendant's verdicts, the publicity recently given to the increasing cost to the public and to the reasons for that increasing cost—show that we may have turned a corner in solving this problem.

***Statement by Mr. Roddewig:***

CLAIR M. RODDEWIG

WE in the railroad business have long been concerned with the problem of the excessive cost of personal injuries. Over the past 17 years, the cost of claims has more than tripled—from $29 million in 1941 to $103 million in 1957. We are also concerned by the fact that the railroad industry is subjected to statutory re-

gulation—the Federal Employees' Liability Act—with respect to claims for injury. While this statute concerns negligence, it has been judicially interpreted to the point that we now have in effect a workmen's compensation act without limits. Inasmuch as over 80 per cent of claim costs are attributed to injuries to employees, the significant role of this statute is readily apparent.

Undoubtedly, you have heard it said that the railroads could do more than they are doing to help themselves. In some instances, there may be an inkling of truth in this comment; however, I am sure that it does not apply to those factors responsible for the substantial increases reflected in our claim costs over the years. My judgment is based primarily on the intensive efforts made by the railroads to prevent accidents. Substantial sums have been spent to make our properties a safer place to work. Educational programs on safety measures at work are continually conducted. It is noteworthy that these efforts have paid off very substantially in the relief of human suffering. Injuries to employees have been reduced by 54 per cent in this 17 year period, while injuries to all persons have been reduced by approximately 46 per cent. Serious injuries have been reduced by an even greater degree. Fatalities to railroad employees on duty decreased from 807 in 1941 to 187 in 1957. Today, the death rate per 100,000 workers in four other major industries is greater than that of the railroads.

Obviously, progress in reducing accidents is not reflected by a corresponding decrease in claim costs. Analysis shows that in recent years the cost per case increased by approximately 400 per cent, while wages and the cost-of-living index increased a little over 200 per cent. Several years ago, the railroads made an exhaustive study of this problem. It was concluded that distortions in medical reports and testimony played a prominent part in the disparity between what such injuries actually cost today and what they should cost.

Many railroads have their own hospitals in which employees are treated without cost by outstanding medical staffs. In most cases, the doctors seem to get along well with the patients. However, when an employee receives an injury of any degree of severity on the job, it is not unusual for him to become dissatisfied with the treatment. This has happened even with patients treated by many of our most outstanding physicians. Usually, it is found that the injured man has employed counsel who has had him examined by a doctor for the purpose of giving a report or testifying in court. Often, the examining doctor reports findings at great variance with those of the doctor treating the patient. If this difference were merely one of opinion, resulting from different schools of thought in the medical profession, we would have no valid complaint. However, the substantial number of miraculous recoveries which occur so soon after money is paid shows this situation to be of a more complicated nature.

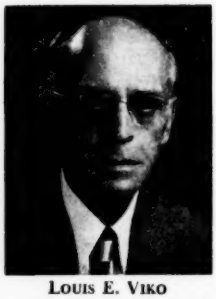
Railroad management desires to compensate its employees and all other claimants adequately and equitably for whatever injuries they receive, but we cannot afford to pay for something that did not or will not happen. Our medical departments and management are interested in rehabilitating injured employees so that they can resume their work. Frequently, however, these efforts are complicated by medical reports and testimony which practically prohibit rehabilitation. I do not know what the answer to this problem may be. We are, however, intensely interested in any discussion which will lead to an equitable and workable solution. Certainly, in most cases it should not be difficult to rule out the kind of medical report or testimony which does not have a substantial basis in fact.

Today, impartial medical testimony plans are receiving a good deal of attention and are operating in New York, Philadelphia, Baltimore and Los Angeles. New York's experience has demonstrated the value of this plan in bringing about equitable settlements and relieving court congestion. The panels have been invoked almost equally by plaintiffs and defendants, with beneficial results to each of them. Plans have not been operating long enough in the other centers to provide any estimate of their value.

In Cleveland, where the medical profession is attempting to have the courts set up impartial medical panels, Judge William K. Thomas of the common pleas court made the following interesting and significant comment. "The medical reports received in my court make it apparent

that doctors sometimes instinctively tend to emphasize what is best for their side. It seems to me that any way to free doctors of the shackles of partisanship would do much to help the administration of justice." I agree wholeheartedly with these sentiments and earnestly recommend the adoption of such a panel in Chicago, where our courts have such a tremendous backlog of cases. It takes from three to four years for a litigant to get a trial in our circuit and superior courts, and a great percentage of cases on the docket involve personal injury. I see no reason why the courts should not anticipate the same benefits from the accelerated disposition of cases which the New York courts obtained when one of the major obstacles, namely, widely divergent medical reports, was removed. The railroads will cooperate completely in achieving this desirable objective.

***Statement by Dr. Viko:***



LOUIS E. VIKO

THE purpose of this discussion is to compare the role of medical witnesses under the former adversary - hearing procedures in the state of Utah with that of the medical panel under the present Utah Workmen's Compensation Law.

Much has been written about the absurdities and inequities of hearings such as those that Ivan C. Rutledge[1] termed "medicolegal tournaments." Having had experience as an attending physician and as a medical expert for both the claimant and the defense under the old law and as chairman of the present panel of internal medicine and cardiovascular diseases of the Utah State Industrial Commission, I have formed strong convictions regarding the proper role of the physician in serving the Commission and the courts, and I would like to point out some of the problems which should be corrected in any equitable plan involving medical issues.

*Former adversary-hearing procedures*—Before a hearing in personal injury cases in former years, the file of the Industrial Commission contained some usually adequate reports of attending physicians regarding the nature of the original injury and any surgical results thereof. However, these reports were generally far from adequate in regard to more remote effects of the injury; furthmore, there was no mechanism by which an inquiry could be made by a competent independent physician for the Commission. The general procedure was for the attending physician to meet before the hearing with the plaintiff's attorney, who tried to condition him to present the facts in the light most favorable to the plaintiff. At the hearing, the physician was expected to express opinions favorable to the plaintiff's claim for compensation. No matter how honest the attending physician, he found it difficult to escape bias due to his personal relation with the patient or his sympathy for the widow.

It thus became necessary for the insurance carrier to present a medical expert to controvert the opinion of the attending physician. Lest this testimony tip the scale too far in the other direction, the plaintiff then needed a medical expert. Despite the integrity of the medical expert, he, too, came to the hearing conditioned as a witness for one party to the proceedings. He was rarely furnished all the medical facts and then permitted to express an ordered logical opinion without interruption at the hearing. Rather, he faced a series of hypothetical questions from each side which were intended to obtain desired answers. The attempts of the opposing attorney to discredit and confuse the witness often resulted in making an honest witness become partisan.

Frequently, in medical testimony, an inequity existed in favor of the insurance carrier. The carrier was always ably represented by a skillful lawyer or claims adjuster, or both; often, the plaintiff was represented by a less skillful legal talent who was willing to accept a contingent fee frowned on by more established members of the profession. In addition, the insurance carrier was able and willing to pay an adequate fee for time spent by the physician at the hearing, while the plaintiff often could not pay the physician at all. An ethical physician charged the insurance carrier according to the time involved, regardless of the verdict in the case; however, the probability of the plaintiff's being able to pay any fee at all might depend on the outcome of the case. When such procedures were in effect, wit-

nesses appeared who, according to Commissioner Wiesley,[2] "tailored their testimony, knowingly, to aid the cause of the party who called them as witnesses."

In spite of these practices, however, I believe that most doctors, lawyers and claims agents intended to be honest and fair. All were caught in a system that hampered and frustrated that intent.

*Medical panel system*—Choice of panel—Under the present system in Utah, there is a single panel of doctors who serve in litigation involving occupational disease. In cases concerning workmen's compensation, there are many medical panels, each chosen to fit the particular case. These panels are composed of specialists in various fields who are chosen by the Commission from a complete list of qualified physicians submitted by the Utah state Medical Association. The chairmanship of the panel does not change; however, membership rotates in order to assure uniformity of approach and expression of new viewpoints.[2] If any panel member finds that he has had previous relations with the claimant or has been consulted about the case, he automatically disqualifies himself. This system permits choice of the best-qualified specialists for a given case; it avoids an undue burden on the time of a few, and secures the support of a large segment of the medical profession.

Procedure—After setting forth conditions under which cases shall be referred to a medical panel and after defining qualifications of panel members, the Utah law[3] directs as follows: "The medical panel shall make such study, take such x-rays, and perform such tests, including postmortem examinations where authorized by the Commission, as it may determine, and thereafter shall make a report in writing to the Commission in a form prescribed by the Commission and shall make such additional findings as the Commission shall require." Thus, the panel is given wide authority, and it cannot be overemphasized that the law specifically directs the panel to make its own investigation and not to rely solely on the data supplied to it.

The panel begins to function when each member receives a formal order from the Commission and the panel chairman receives the complete original file on the case. Excessive routine procedures are avoided. The chairman writes to the claimant or to his lawyer, asking for specific information; a similar letter is sent to the attending physician, requesting amplification or clarification of reports on file and asking permission for the panel to review the hospital record. Cooperation in these procedures has been excellent. Insurance carriers often send photostats of all material on file; attending physicians reply to questions and send x-rays, laboratory data, electrocardiograms, etc.; frequently, they send the complete records of the case. A review of the hospital record by the panel is considered of great importance, as it shows in detail the exact sequence of events following the accident. The panel chairman summarizes the hospital record and, occasionally, brings it to a panel meeting.

To this point, the procedure is more or less routine, but it subsequently varies greatly with the individual case. It may be necessary to clarify certain discrepancies; the panel may direct that either the attending physician or other physicians make further examinations, the expense of which is paid by the Commission. Frequently, the panels on occupational disease and head injuries hospitalize patients for new x-rays, laboratory studies and even lung biopsies.

When the panel chairman is satisfied, after consulting other panel members, that the record is complete, he summarizes the original file and all new information, supplying copies of the summary to each panel member and to the Commissioner; a copy also is attached to the file of the Commission. After the complete file, including all correspondence and reports, has been studied by each panel member, the entire panel meets with the Commissioner for discussion. The claimant may or may not be examined by the panel at this meeting. Members of panels in orthopedic cases always examine the patient. The attending physician may meet with the panel, but he is not present during final deliberations. It has been found that a biased opinion of an attending physician disappears during discussion with panel doctors.

If the panel members reach a conclusion, it is recorded during the meeting for signature by all members and is returned with the file to the Commission. Decision may be delayed for further examination of the claimant or for study of the issues. The panel may wish to consult nationally known authorities outside the state. Occasionally, the panel is unable to resolve discrepancies regarding such matters as the exact nature of the accident, contradictory statements on

the previous health of the claimant, etc. In such cases, the Commission is requested to hold a formal hearing on these matters, and the panel further deliberates on the transcript of this hearing.

Recently, medical panels have devoted more attention to positive efforts to return the claimant to self-support. This involves rating the degree and permanence of the disability in terms of any occupation. The panel may recommend that compensation be awarded for a limited period, at the end of which the case is open to review. This often results in the claimant's returning to work in the same or a different job. In other cases, rehabilitation retraining may be recommended.

Advantages of the panel system—The use of medical panels in cases involving personal injury results in more just and uniform decisions based on complete and impartial investigation and on unbiased expert medical judgment. Difficult cases, in which the claimant formerly could not have secured adequate investigation to support his claim, are now receiving equitable settlements. Unedifying adversary-oriented medical testimony and the professional medical witness no longer exist. The consistency of medical findings and decisions of the Commission have led to a marked decrease in the number of unreasonable claims filed with the Commission. The honest attending physician is no longer "on the spot." As Commissioner Wiesley stated, "Fear, suspicion, bias and hatred have been eliminated because expert honest medical opinion is now available to both parties at no cost to them."

According to Mr. Wiesley, there have been approximately 300 reports from the panel on silicosis and approximately 150 reports under the accident compensation law since the medical panel system was instituted. None of these cases have been appealed on medical issues, although the law provides both parties the right to appeal within 15 days. Formal hearings by the Commission have been reduced from an average of 300 to 40 per year, including those requested by panels and cases on nonmedical issues. These facts indicate the wide support given the plan of medical panels by labor, industry and the medical and legal professions. Recently, the Utah State Medical Association Committee for Liaison With the State Bar Association suggested to its counterpart committee of the Bar Association that they jointly explore the possibility of extending some such medical panel system to district and federal courts.

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***Statement by Dr. Wade:***

Preston A. Wade

THE average practicing physician or surgeon has had limited experience in court procedure and usually has a peculiar idea of methods involved in settling cases of personal injury. Most doctors have only vague notions about the operation of the courts, many of their ideas being based on a few unpleasant experiences while giving "expert testimony."

The young doctor who appears in court for the first time is always amazed by the long delays and the interminable testimony from seemingly unimportant witnesses regarding details that have no apparent bearing on the case. He discovers that the proceedings are ensnarled in confusing red tape that seems to bury the few significant facts that might possibly bring out the truth. Most of the principals involved seem intent on emphasizing the important points to their own advantage and on covering up possibly helpful facts brought out by the opposition. On many occasions, it becomes obvious that either one or the other of two witnesses is deliberately falsifying the facts. Furthermore, when he is finally put on the witness stand after a long wait, the physician finds that in the cross-examination his integrity is questioned and his professional ability attacked; he is placed in the position of making contradictory responses to tricky questions.

After a few appearances in court and one or two attempts to outwit a trial lawyer, the physician learns to confine his answers to medical facts and to leave the

interpretation to others. He shares the layman's idea that the successful lawyer is one who wins a hopeless case, in spite of the facts, by his adroitness and cleverness in handling a jury, or, as stated by Joseph Welch, that "the successful lawyer is one who, by his magic, can sway a jury."

All of these impressions, ill-founded as they may be, have caused the average physician to avoid appearances in court if at all possible. Ethical physicians and surgeons have become unwilling to testify unless they are actually involved in treating the patient in the case. Thus, the average medical witness has not always been of the highest caliber, and his professional knowledge and ability have not always been adequate to serve the best interests of all who are concerned.

Because of these conditions, the responsible members of the medical profession in New York were gratified when the justices of the supreme court made an effort to clarify the situation and to expedite the outcome of personal injury cases. When a special committee of the Association of the Bar of the City of New York made plans to set up a panel of medical experts, it was found that most of the doctors invited to serve accepted with enthusiasm and a spirit of cooperation.

*Choice of panel members*—A panel of 97 specialists was organized in New York County. Most of the physicians chosen by the committee for the medical panel hold professional rank in the various medical schools in New York or have comparable positions in the larger hospitals. All have achieved considerable reputations in their specialties. None of those invited to join the panel are regularly involved in medicolegal affairs, but all have had sufficient experience to understand the situation which precipitated the action. During the first two years of the experiment, all physicians accepted their assignments without question and were interested in learning the results of the new plan.

My experience as a member of the panel has been most gratifying. I found that all concerned accepted the impartial medical witness without reservation and did all they could to assist the medical expert to arrive at a decision promptly and with as little inconvenience as possible.

*Procedure*—The member of the panel is usually introduced to the case by the Medical Report Office, which acquaints him with the facts and indicates the differences of opinion and the particular discrepancies in the medical evidence that necessitate an impartial examination. This office may specify a medical point on which an impartial opinion is desired. An appointment is made for the physician to examine the patient; in the meantime, the Medical Report Office makes certain that the attorneys for the plaintiff and the defendant provide the examiner with all the medical data in their possession, including x-rays, photostatic copies of hospital charts, and doctors' reports. At the examination, the plaintiff is accompanied by his counsel; occasionally, an attorney for the defendant also attends.

In every case in which I have served, both the plaintiff and the attorneys have helped in every way to facilitate the examination. I have been able to question the plaintiff, obtain the necessary history, and make the required examination. If I determined that it was necessary to take x-rays in my office, I was able to do so. There was never any reluctance on the part of the client or his attorney, and the examinations were always carried out in the most informal and friendly atmosphere.

The report of the examination, similar to one that might be prepared for a referring physician, is submitted in triplicate to the Medical Report Office. As accurately as possible, it answers the questions which have led to the discrepancies in the medical testimony previously presented. After reviewing this report, the presiding judge may, if he chooses, call the examiner and informally question him further to clarify points which will help in making a decision.

There are no set fees for any given time or case. In most instances, the fees have been within reason. The policy of the Medical Report Office is to pay the fee asked by the examining doctor. If the fee is considered to be unreasonable, the panel member is not asked to take part in further cases.

It is inevitable that the panel expert be asked to appear to testify in some of the cases that go to trail. When I have been asked to testify, I have been extended every courtesy. At no time was my professional standing challenged, nor was there any attempt to imply that my testimony was anything but the truth. In most instances, I have been given sufficient notice and have been asked to appear at a convenient time; I have always been paid my usual fee.

*Results*—Investigation of the cases in which panel experts have participated shows that many early settlements have been effected; frequently, a more equitable settlement has been made than might have resulted if impartial medical testimony had not been requested. The early settlements of claims also have resulted in benefits to the injured person, since symptoms (whether real or imagined) often may be aggravated or even become chronic by long-continued litigation.

Results of a questionnaire on this plan, sent by the special committee to 15 panel members, indicated that the selection of specialists was satisfactory, that both plaintiff and defendant cooperated and assisted in the examination, and that at no time was any pressure of persuasion exerted on the examiner. Each panel member indicated that adequate time was allowed for the examination and for the preparation of the report, that the office of the supreme court was extremely cooperative, understanding and helpful, and that the arrangements for the appearance at the trial were satisfactory. The interrogation by the lawyers of both sides was reported to be reasonable and productive, and the testimony was considered important and decisive in the outcome of the trial. Few panel members had any criticisms of the panel system or suggestions for its improvement. Many physicians on the panel were enthusiastically in favor of the system and believed that it would add greatly to the administration of justice in such cases.

From this pilot study, it is clear that the use of medical panel in litigation involving personal injury is a significant forward step in the development of the system of justice in New York, and that adoption of this program on a national or statewide basis would be advantageous to all concerned.